Regular Meeting of the

Santa Clara County Health Authority Governing Board

Thursday, March 28, 2019, 2:30 PM - 5:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

Via Teleconference
Residence
1985 Cowper Street
Palo Alto, CA 94301

AGENDA

1.	**Roll Call**	Mr. Brownstein	2:30	5 min
2.	**Public Comment** Members of the public may speak to any item on the agenda; two minutes per speaker. The Board reserves the right to limit the duration of public comment period to 30 minutes.	Mr. Brownstein	2:35	5 min
	Announcement Prior to Recessing into Closed Session Announcement that the Governing Board will recess into closed session to discuss Item No. 3(a) & (b) below.	Mr. Brownstein		
3.	**Adjourn to Closed Session**		2:40	

a. **Existing Litigation** (Government Code Section 54956.9(d)(1)):
It is the intention of the Governing Board to meet in Closed Session to confer with Legal Counsel regarding consolidated cases before the Board Administration of the California Public Employees' Retirement System:

i. In the Matter of the Appeal Regarding Membership Exclusion of Foundation Employees by Santa Clara County Health Authority (Respondent) and Craig W. Walsh (Respondent) Case Number: CalPERS Case No. 2017-1114; OAH No. 2018051223.

ii. In the Matter of Appeal Regarding Membership Exclusion of Foundation Employees by Santa Clara County Health Authority (Respondent) and Melodie U. Gellman (Respondent) Case Number: CalPERS Case No. 2017-1115; OAH Case No. 2018051029.

b. **Contract Rates** (Welfare and Institutions Code Section 14087.38(n)):
It is the intention of the Governing Board to meet in Closed Session to discuss plan partner rates.

4.	**Report from Closed Session**	Mr. Brownstein	3:20	5 min
5.	**Approve Consent Calendar and Changes to the Agenda** Items removed from the Consent Calendar will be considered as regular agenda items. **Possible Action:** Approve Consent Calendar	Mr. Brownstein	3:25	5 min

a. Approve minutes of the December 13, 2018 **Regular Board** Meeting

b. Accept minutes of the February 28, 2019 **Executive/Finance Committee** Meeting
- Ratify approval of the November and December 2018 Financial Statements
- Ratify approval of the Reappointment of Moss Adams as the Plan's External Auditor
- Ratify acceptance of the Network Detection & Prevention Report

c. Accept minutes of the February 28, 2019 **Compliance Committee** Meeting
- Ratify acceptance of the Compliance Activity Report
- Ratify approval of the Compliance Policies
  - CP.09 Exclusion Screening
  - CP.10 Compliance Training
  - CP.15 Standards of Conduct
  - CP.12 Annual Compliance Program Effectiveness Audit
  - CP.17 Risk Assessment
  - CP.16 First Tier, Downstream & Related Entity & Vendor Contracting (FDR)
  - CP.07 Corrective Action Plan
- Ratify acceptance of the Fraud, Waste, and Abuse Report

d. Accept minutes of the February 13, 2019 **Quality Improvement Committee** Meeting
- Ratify approval of the Health Education Program Description 2019, Work Plan 2019 and Evaluation 2019
- Ratify approval of the Cultural and Linguistics Program Description 2019, Work Plan 2019 and Evaluation 2019
- Ratify approval of the Quality Improvement Policies
  - QI.05 Potential Quality of Care Issues
  - QI.07 Physical Access Compliance
  - QI.10 IHA and IHEBA Assessments
  - QI.28 Health Homes Program
- Ratify approval of the American Disabilities Act (ADA) Work Plan 2019
- Ratify approval of the Timely Access and Availability MY2018 Survey
- Ratify acceptance of Committee Reports
  - Credentialing Committee – December 12, 2018
  - Pharmacy and Therapeutics Committee – September 20, 2018
  - Utilization Management Committee – October 17, 2018

e. Accept minutes of the February 13, 2019 **Provider Advisory Council** Meeting
f. Accept minutes of the March 12, 2019 **Consumer Advisory Committee** Meeting

6.	**Quality Improvement Program Description 2019** Review the 2019 Quality Improvement Program Description. **Possible Action:** Approve the Quality Improvement Program Description 2019	Ms. Nakahira	3:30	5 min
7.	**Policy Approval:** GO.01 v2 Organizational Policies Consider revisions to Policy GO.01. **Possible Action:** Approve revised Policy GO.01 v2 Organizational Policies	Ms. Tomcala	3:35	5 min
8.	**Appointment of Consumer Advisory Committee (CAC) Co-Chair** Consider appointment of Evangeline Sangalang to co-chair the CAC. **Possible Action:** Approve appointment of Evangeline Sangalang to co-chair the Consumer Advisory Committee	Mr. Brownstein	3:40	5 min
9.	**Governing Board Meeting Time** Consider moving the standing meeting time to earlier in the day. **Possible Action:** Approve moving the meeting time of the Governing Board	Ms. Tomcala	3:45	5 min
10.	**CEO Update** Discuss status of current topics and initiatives. **Possible Action:** Accept CEO Update	Ms. Tomcala	3:50	15 min
11.	**Compliance Report** Review and discuss quarterly compliance activities. **Possible Action:** Accept Compliance Report	Ms. Larmer	4:05	15 min
12.	**January 2019 Financial Statements** Review recent organizational financial performance. **Possible Action:** Approve the January 2019 Financial Statements	Mr. Cameron	4:20	15 min
13.	**Funding for Enrollment Assistance** Consider continuation of collaboration with The Health Trust to provide enrollment assistance to the community. **Possible Action:** Approve funding to support the Health Trust in providing enrollment assistance through June 2020	Ms. Tomcala	4:35	10 min
14.	**Health Homes Update** Discuss status of Health Homes Program development. **Possible Action:** Approve allocation of start-up funding for community-based care management entities (CB-CMEs) from the Special Project Board Discretionary Fund	Ms. Nakahira Mr. Cameron Ms. Tomcala	4:45	10 min

15. Publicly Available Salary Schedule Ranges Consider changes to the Publicly Available Salary Schedule. **Possible Action:** Approve Publicly Available Salary Schedule	Ms. Valdez	4:55	5 min
16. Adjournment	Mr. Brownstein	5:00	

Notice to the Public—Meeting Procedures

- Persons wishing to address the Governing Board on any item on the agenda are requested to advise the Recorder so that the Chairperson can call on them when the item comes up for discussion.
- The Governing Board may take other actions relating to the issues as may be determined following consideration of the matter and discussion of the possible action.
- In compliance with the Americans with Disabilities Act, those requiring accommodations in this meeting should notify Rita Zambrano 48 hours prior to the meeting at 408-874-1842.
- To obtain a copy of any supporting document that is available, contact Rita Zambrano at 408-874-1842. Agenda materials distributed less than 72 hours before a meeting can be inspected at the Santa Clara Family Health Plan offices at 6201 San Ignacio Ave, San Jose, CA 95119.
- This agenda and meeting documents are available at www.scfhp.com

Regular Meeting of the

Santa Clara County Health Authority Governing Board

Thursday, December 13, 2018, 2:30 PM - 5:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

DRAFT

Members Present
Brian Darrow, Vice-Chair
Dolores Alvarado
Darrell Evora
Kathleen King
Liz Kniss
Ria Paul, M.D.
Paul Murphy
Susan Murphy
Evangeline Sangalang
Jolene Smith *(via telephone)*
Brenda Taussig *(via telephone)*
Linda Williams *(via telephone)*

Members Absent
Bob Brownstein, Chair

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer
Robin Larmer, Chief Compliance & Regulatory Affairs Officer
Chris Turner, Chief Operating Officer
Laurie Nakahira, D.O., Chief Medical Officer
Jonathan Tamayo, Chief Information Officer
Sharon Valdez, VP of Human Resources
Neal Jarecki, Controller
Johanna Liu, Director of Quality & Pharmacy
Rita Zambrano, Executive Assistant

Others Present
Melanie Miller, Shield Health Care

1. Roll Call

Brian Darrow, Vice-Chair, called the meeting to order at 2:30 pm. Roll call was taken and a quorum was established. Mr. Darrow welcomed Susan Murphy as a new member of the Santa Clara County Health Authority Governing Board.

2. Public Comment

There were no public comments.

3. Approve Consent Calendar and Changes to the Agenda

Mr. Darrow recommended moving Agenda Items 15. Adjourn to Closed Session; 16. Report from Closed Session; & 17. Annual CEO Evaluation to immediately follow Item 4. CEO Update.

> **It was moved, seconded, and unanimously approved** to move Agenda Items 15, 16, & 17 immediately following Item 4.

Paul Murphy, Board Member, motioned to move Agenda Items 7. Conflict of Interest; 13. Network Detection & Prevention Report; and 14. Publicly Available Salary Schedule Ranges to the Consent Calendar to allow adequate discussion time on remaining agenda items.

Ms. Tomcala noted that C-Biz Talent & Compensation Solutions recommended a 1.95% upward adjustment of all salary ranges to ensure range minimums and maximums remain competitive to the market.

It was moved, seconded, and unanimously approved to move Agenda Items 7, 13, & 14 to the Consent Calendar.

Mr. Darrow presented the Consent Calendar and indicated all items would be approved in one motion.

a. Approve minutes of the September 27, 2018 **Regular Board** Meeting

b. Accept minutes of the October 25, 2018 **Executive/Finance Committee** Meeting
- Ratify approval of the FY 2017-18 External Independent Auditor's Report
- Ratify approval of the August 2018 Financial Statements
- Ratify approval to pay anniversary bonuses for the latest milestone achieved by current staff prior to July 2018

c. Accept minutes of the November 15, 2018 **Executive/Finance Committee** Meeting
- Ratify approval of the September 2018 Financial Statements

d. Accept minutes of the November 15, 2018 **Compliance Committee** Meeting
- Ratify acceptance of the Compliance Activity Report
- Ratify acceptance of the Compliance Monitoring Report
- Ratify acceptance of the Fraud, Waste, and Abuse Report

e. Accept minutes of the October 10, 2018 **Quality Improvement Committee** Meeting
- Ratify approval of the Email Response Evaluation
- Ratify approval of the Accessibility of Services Analysis
- Ratify approval of the Continuity and Coordination between Medical and Behavioral Healthcare
- Ratify approval of the Annual Assessment of Experience with UM Process
- Ratify approval of the Assessment of Physician Directory Adequacy
- Ratify approval of the Member Understanding of Marketing Information Analysis
- Ratify acceptance of Committee Reports
  - Credentialing Committee – August 15, 2018
  - Pharmacy & Therapeutics Committee - June 21, 2018
  - Utilization Management Committee – July 18, 2018

f. Accept minutes of the December 5, 2018 **Quality Improvement Committee** Meeting
- Ratify approval of MedImpact Audit CAP
- Ratify approval of Quality and Accuracy Assessment of Pharmacy Benefit Information on the Member Portal
- Ratify approval of Quality and Accuracy Assessment of Pharmacy Benefit and Personalized Information
- Ratify approval of Performance Evaluation of Clinical Practice Guidelines
- Ratify approval of Member Experience Analysis
- Ratify approval of Member Satisfaction with Complex Case Management Analysis
- Ratify approval of Continuity and Coordination of Medical Care Analysis
- Ratify approval of Policy QI.28 Health Homes Program
- Ratify approval of Network Adequacy Assessment
- Ratify acceptance of Committee Reports
  - Credentialing Committee – October 3, 2018
  - Pharmacy and Therapeutics Committee – September 20, 2018

- Utilization Management Committee – October 17, 2018

g. Accept minutes of the November 14, 2018 **Provider Advisory Council** Meeting

h. Accept minutes of the December 11, 2018 **Consumer Advisory Committee** Meeting

i. **Conflict of Interest Code**
Consider revisions to the Conflict of Interest Code.
Possible Action: Adopt resolution approving the revised Conflict of Interest Code

j. **Network Detection and Prevention Report**
Review report on firewall intrusion, detection, and prevention efforts.

k. **Publicly Available Salary Schedule Ranges**
Consider changes to the Publicly Available Salary Schedule.
Possible Action: Approve Publicly Available Salary Schedule

It was moved, seconded, and the Consent Calendar was **unanimously approved.**

4. CEO Update

Christine Tomcala, Chief Executive Officer, welcomed Laurie Nakahira, D.O., Chief Medical Officer, and noted that Dr. Jeff Robertson would stay on with the Plan in a part-time Medical Director role.

Ms. Tomcala reported that DHCS had erred in calculating the previously-announced auto-assignment rate. SCFHP's rate for 2019 is 62%vs. 66% in 2018.

Ms. Tomcala noted the Plan has been actively searching for a location for a Satellite Office and indicated there are not many suitable properties on the market. The Plan will renew its effort in the New Year.

There was discussion regarding the County proposal to purchase O'Connor and St. Louise Regional hospitals. Court and regulatory approval of the sale is pending.

Ms. Tomcala presented the Plan's published statement regarding the Proposed Public Charge Rule. The Plan is encouraging members to continue to seek regular medical care and continue using the resources the county is proud to offer. We will continue to monitor developments.

It was moved, seconded and unanimously approved to accept the CEO Update.

5. Adjourn to Closed Session

a. **Contract Rates** (Welfare and Institutions Code Section 14087.38(n)):
The Governing Board met in Closed Session to discuss plan partner rates.

b. **Contract Rates** (Welfare and Institutions Code Section 14087.38(n)):
The Governing Board met in Closed Session to discuss plan partner rates.

c. **Publicly Employee Performance Evaluation** (Government Code Section: 54957(b)):
The Governing Board met in Closed Session to consider the performance evaluation of the Chief Executive Officer.

6. Report from Closed Session

Mr. Darrow reported the Governing Board met in Closed Session to discuss Items 5 (a), (b), and (c). Mr. Darrow noted action was taken to approve Management's recommendation to renew the contract with MedImpact as the Plan's Pharmacy Benefit Manager (PBM).

It was also determined that an advisory working group should be convened to advise the Plan on contracting on an as needed basis.

7. Annual CEO Evaluation Process

Dolores Alvarado, Chair of the ad hoc CEO Evaluation Subcommittee, reported on the 2018-19 annual performance and compensation review of the CEO. Based on the positive evaluation of the CEO, it was recommended that the CEO receive a 3% annual salary increase effective July 1, 2018 and a 7% incentive bonus.

It was moved, seconded, and the recommended annual salary increase and incentive bonus for the CEO was **unanimously approved.**

8. Annual Report to the County Board of Supervisors

Ms. Tomcala presented the combined Annual Report of the Santa Clara County Health Authority and Santa Clara Community Health Authority, summarizing status updates and financial highlights for fiscal year 2017-18 – including compliance program and systems enhancements, collaboration with Valley Health Plan and SCVHHS on Whole Person Care, and build out of new office space.

It was moved, seconded, and the Annual Report to the County Board of Supervisors was **unanimously approved.**

9. Compliance Report

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, summarized the CMS Program Audit results. The Final Audit Report reflects 6 Immediate Corrective Action Required Conditions (ICARs) and 25 Corrective Action Required Conditions (CARs). The Final Report differed from the Preliminary Report in that it eliminated two Conditions, converted eleven Conditions to Observations, and converted one ICAR to a CAR. The Plan has 30 days to submit CAPS for all CARs (ICAR CAPs have previously been submitted and accepted by CMS). The Plan will likely know whether and in what amount it will be assessed penalties by February 2019.

Ms. Larmer reminded the Board that an investigation into a whistleblower complaint regarding potential fraud had been completed and it was determined there was no fraudulent activity.

It was moved, seconded, and the Compliance Report was **unanimously approved.**

Darryl Evora left the meeting at 4:47 pm.

10. October 2018 Financial Statements

Dave Cameron, Chief Financial Officer, presented the October 2018 financial statements, which reflected a current month net surplus of $250 thousand ($174 thousand unfavorable to budget) and a fiscal year-to-date surplus of $248 thousand ($433 thousand unfavorable to budget). Enrollment declined by 1,336 from the prior month to 255,311 members. Medi-Cal enrollment has declined since October 2016 while CMC membership has grown modestly over the past few months due to continued outreach efforts. Revenue reflected a favorable current month variance of $5.6 million (6.9%) largely due to revised estimates of calendar year 2018 CMC & MLTSS rates. Medical expense reflected an unfavorable current month variance of $5.9 million (7.8%) largely due to increased inpatient, LTC and pharmacy expenses and higher estimates of prior period medical expenses. Administrative expense reflected an unfavorable current month variance of $203 thousand (4.3%). Personnel expenses were at budget while non-personnel expenses exceeded budget due to the timing of certain expenses. The balance sheet reflected a Current

Ratio of 1.26:1, versus the minimum required by DMHC of 1.0:1. Tangible Net Equity of $178 million represented 506.2% of the minimum required by DMHC of $35.2 million.

It was moved, seconded, and the October 2018 Financial Statements were **unanimously approved.**

Liz Kniss left the meeting at 4:52 pm.

11. Fund CalPERS Retiree Healthcare Liability

Mr. Cameron noted that SCFHP participates in the California Public Employees' Retirement System's (CalPERS) California Employers' Retiree Benefit Trust (CERBT) program to provide medical benefits to retirees. He further noted that, in December 2017, the Governing Board accepted management's recommendation to fund the June 30, 2016 OPEB liability of $5.3 million in three annual installments. As of June 30, 2017, the OPEB liability was 51.8% funded and the Plan's actuaries have recommended a second installment contribution of $1.332 million be made by December 31, 2018.

It was moved, seconded, and the Resolution to Fund CalPERS Other Post-Employment Benefits Liability was **unanimously approved.**

12. Board Discretionary Fund

Mr. Cameron provided the Board with the Special Project Board Discretionary Fund Policy (which was previously approved) and recommended setting aside $2.2 million for strategic investments. The Executive/Finance Committee may approve projects up to $100,000, while the Governing Board needs to approve larger amounts.

It was moved, seconded, and unanimously approved to make $2.2 million available for the Special Project Board Discretionary Fund (Policy GO.02)**.**

13. Board Discretionary Fund Expenditures

Ms. Tomcala discussed the submission of grant funding requests from the Community Clinics last April, and the subsequent Board development and approval of a Board Discretionary Fund for strategic investments. Upon review, the majority of the clinic requests did not meet the eligibility criteria in the Special Project Board Discretionary Fund Policy. Ms. Tomcala indicated she and Dr. Nakahira would be scheduling visits with the Community Clinics and would further discuss the clinics' requests at that time.

A suggestion was made that the Board have further discussion at a future meeting regarding the criterion that funding will not financially benefit any Santa Clara County Health Authority official.

14. Signature Authority Policy

Mr. Cameron presented a cash disbursements policy which outlines who has authority and responsibility for approval of various expenditures. All contracts in excess of $250,000 require the review and approval of the Governing Board or the Executive/Finance Committee.

It was moved, seconded, and Policy FIN.03 Cash Disbursements was **unanimously approved.**

15. Adjournment

The meeting was adjourned at 5:02 pm.

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Brian Darrow, Vice-Chair

Regular Meeting of the

Santa Clara County Health Authority
Executive/Finance Committee

Thursday, February 28, 2019, 11:30 AM - 1:00 PM
Santa Clara Family Health Plan, Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

MINUTES - Draft

DRAFT

Members Present
Brian Darrow, Chair
Dolores Alvarado
Liz Kniss
Linda Williams

Members Absent
Bob Brownstein

Staff Present
Christine Tomcala, Chief Executive Officer
Dave Cameron, Chief Financial Officer *(via telephone)*
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Neal Jarecki, Controller
Sharon Valdez, VP, Human Resources
Benjamin McLarin, Director, Infrastructure & Support
Rita Zambrano, Executive Assistant

Other Present
Daphne Annett, Burke, Williams & Sorenson, LLP *(via telephone)*

1. **Roll Call**

   Brian Darrow, Chair, called the meeting to order at 11:30 am. Roll call was taken and a quorum was not established.

2. **Public Comment**

   There were no public comments.

3. **Adjourn to Closed Session**

   a. **Existing Litigation**
   The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding CalPERS Case No. 2017-1114; OAH Case No. 2018051223.

Liz Kniss and Dolores Alvarado joined the meeting at 11:43 am.

b. **Existing Litigation**
The Executive/Finance Committee met in Closed Session to confer with Legal Counsel regarding CalPERS Case No. 2017-1115; OAH Case No. 2018051029.

Mr. Darrow recused himself.

c. **Contract Rates**
The Executive/Finance Committee met in Closed Session to discuss plan partner rates.

Mr. Darrow rejoined the meeting.

4. Report from Closed Session

Mr. Darrow reported the Executive/Finance Committee met in Closed Session to discuss Items 4(a) & (b). The Committee authorized counsel to explore options for a potential settlement of the Walsh/Gellman claims in a manner consistent with previous direction of the Board.

Ms. Tomcala noted that the Committee discussed Item 4 (c).

5. Meeting Minutes

The minutes of the November 15, 2018 Executive/Finance Committee were reviewed.

It was moved, seconded, and the November 15, 2018 Executive/Finance Committee Minutes were **unanimously approved.**

6. November and December 2018 Financial Statements

Neal Jarecki, Controller, presented the November and December 2018 financial statements. The November statements reflected a current month net loss of $100 thousand ($705 thousand unfavorable to budget) and a year-to-date net surplus of $148 thousand ($1.1 million unfavorable to budget). The December statements reflected a current month net surplus of $7.9 million ($7.1 million favorable to budget) and year-to-date net surplus of $8.1 million ($6.0 million favorable to budget).

Mr. Jarecki provided an overview of November results and elaborated on the December results. He noted that enrollment declined to 253,735 members. Medi-Cal enrollment has declined since October 2016, largely in the Non-Dual Adult and Child categories of aid, and a continued decline was assumed in the annual budget. CMC membership has grown modestly over the past few months due to continued outreach efforts. Revenue reflected a favorable current month variance of $7.6 million (13.2%) largely due to additional accruals from DHCS. Medical expenses reflected an unfavorable current month variance of $3.9 million (5.2%) due largely to increased utilization and higher pharmacy costs. Administrative expenses reflected a favorable current month variance of $67 thousand (1.5%) and a favorable year-to-date variance of $627 thousand (2.2%). The balance sheet reflected a current ratio of 1.26:1 versus the minimum required by DMHC of 1.0:1. Tangible Net Equity (TNE) was $186.1 million, or 537.4% of the minimum required by DMHC of $34.6 million. YTD Capital Investments of $5.0 million were made and largely represented building renovation costs.

It was moved, seconded, and the November and December 2018 Financial Statements were **unanimously approved.**

7. Reappointment of External Auditor

Mr. Jarecki noted that the Plan's current independent auditing firm is Moss Adams LLP. Moss Adams audits the majority of the local health plans and has a prominent healthcare practice. Moss-Adams is in the third year of its current engagement. Management recommends and seeks the Committee's approval to extend the term of engagement an additional two years with no change to the current pricing.

It was moved, seconded, and the reappointment of Moss Adams as the Plan's External Auditor was **unanimously approved.**

8. Compliance Update

Robin Larmer, Chief Compliance and Regulatory Affairs Officer, discussed the 2018 CMS Program Audit. She presented the CMS Audit Activity Tracker, reflecting progress in completion of the Corrective Action Plans (CAPs) implemented in response to the Immediate Corrective Action Required Conditions (ICARs) and Corrective Action Required Conditions (CARs) identified by CMS.

Most tasks are complete or substantially on track. However, Ms. Larmer has some concerns about the Beacon implementation and some of the reports that are not yet being produced in the required format. . The Plan has implemented work-around processes to ensure that Compliance receives all required data while implementation issues continue to be addressed. Ms. Larmer also noted some other general areas of concern, including staffing, and in particular, the ability of staff to sustain long term the effort required to manage CMS Program Audit remediation along with the demands of simultaneous, multiple state audits and daily work.

Ms. Larmer noted that, as anticipated, the Plan was assessed a civil monetary penalty in the amount of $39 thousand in connection with the CMS Program Audit. The penalty was based on two Conditions, which had the potential to impact a total of 440 and 480 members, respectively. The Plan mitigated the amount of the penalty by demonstrating effective remedial actions that avoided impact for several of the members.

Ms. Larmer further noted that the California State Auditor's office selected three plans for review in its recent audit, and there were no recommendations or findings related to SCFHP.

It was moved, seconded, and the Compliance Update was **unanimously approved.**

9. Network Detection and Prevention Report

Benjamin McLarin, Director of Infrastructure and Support, reported on firewall intrusion, detection, and prevention efforts.

It was moved, seconded, and unanimously approved to accept the Network Detection & Prevention Report.

10. CEO Update

Christine Tomcala, Chief Executive Officer, reported the percentage of membership attributed to the Community Clinics, noting that 50% of the Medi-Cal membership is with Valley Health Plan and within Valley Health Plan, 35% of that membership is with the Community Clinics (approximately 42,000 Medi-Cal members). Valley Medical Center clinics serve 63% (approximately 75,000 members).

Ms. Tomcala announced the Plan has achieved 3-year NCQA Accreditation for the Cal MediConnect line of business. She also noted this is component of the Team Incentive Program compensation for 2018-19, worth a 1% payout to employees next fall.

Ms. Tomcala updated the Committee on the status of locating space for a Satellite Office Community Resource Center.

Ms. Tomcala further noted she and Laurie Nakahira, Chief Medical Officer, are meeting with each of the community clinics to discuss funding requests, and to give Dr. Nakahira the opportunity to visit each clinic and discuss opportunities where we can collaborate.

Dolores Alvarado left the meeting at 1:10 pm.

It was moved, seconded, and unanimously approved to accept the CEO Update.

11. Adjournment

The meeting was adjourned at 1:10pm.

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Brian Darrow, Chair

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Five Months Ended November 30, 2018

Agenda

Santa Clara Family Health Plan.

Financial Highlights

	MTD		YTD	
Revenue	$89 M		$425 M	
Medical Expense (MLR)	$85 M	95.2%	$402 M	94.7%
Administrative Expense (% Rev)	$4.6 M	5.1%	$23.4 M	5.5%
Other Income/Expense	$219,137		$848,515	
Net Surplus (Loss)	**($99,874)**		**$148,266**	
Cash on Hand			$219 M	
Net Cash Available to SCFHP			$207 M	
Receivables			$517 M	
Total Current Assets			$744 M	
Current Liabilities			$596 M	
Current Ratio			1.25	
Tangible Net Equity			$178 M	
% of DMHC Requirements			**511.2%**	

Financial Highlights

Net Surplus (Loss)	Month: Loss of -$0.1M is -$0.7M or -116.5% unfavorable to budget of $0.6M. YTD: Surplus of $0.1M is $-1.1M or -88.5% unfavorable to budget of $1.3M.
Enrollment	Month: Membership was 254,484 (582 or 0.2% favorable budget of 253,902). YTD: Member months was 1.3M (1.0K or 0.1% favorable budget of 1.3M).
Revenue	Month: $89.2M ($8.5M or 10.5% favorable to budget of $80.7M) YTD: $424.9M ($19.9M or 4.9% favorable to budget of $405.0M)
Medical Expenses	Month: $84.9M (-$9.4M or -12.5% unfavorable to budget of $75.5M) YTD: $402.2M (-$22.9M or -6.0% unfavorable to budget of $379.3M)
Administrative Expenses	Month: $4.6M (-$13.6K or -0.3% unfavorable to budget of $4.6M) YTD: $23.4M ($0.6M or 2.3% favorable to budget of $23.9M)
Tangible Net Equity	$178.2M (511.2% of DMHC minimum requirement of $34.9M)
Capital Expenditures	YTD Capital Investment of $4.5M vs. $10.9 annual budget was primarily due to building renovation.

Detail Analyses

Enrollment

- Total enrollment has decreased since fiscal year-end June 30, 2018 by 4,991 members or -1.9%.
- As detailed on page 16, much of the enrollment decline has been in the Medi-Cal Non-Dual Child and Adult categories of aid. Medi-Cal Dual enrollment has stabilized while CMC enrollment has grown due to outreach efforts.
- FY19 Membership Trends:
  - Total Medi-Cal membership has decreased since the beginning of the fiscal year by 2.2%. Over 12 months, enrollment has decreased 5.9%.
  - CMC membership has increased since the beginning of the fiscal year by 1.6%. Over 12 months, enrollment has increased 3.8%.
  - Healthy Kids membership has increased since the beginning of the fiscal year by 8.3%. Over 12 months, enrollment has increased 49.1%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of November 2018			For Five Months Ending November 30 2018				
	Actual	Budget	Variance	Actual	Budget	Variance	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	243,399	243,358	0.0%	1,227,485	1,228,323	-(0.1%)	1,305,114	-(5.9%)
Healthy Kids	3,460	2,909	18.9%	16,305	14,545	12.1%	12,103	34.7%
Medicare	7,625	7,635	-(0.1%)	37,889	37,775	0.3%	36,988	2.4%
Total	**254,484**	**253,902**	**0.2%**	**1,281,679**	**1,280,643**	**0.1%**	**1,354,205**	**-(5.4%)**

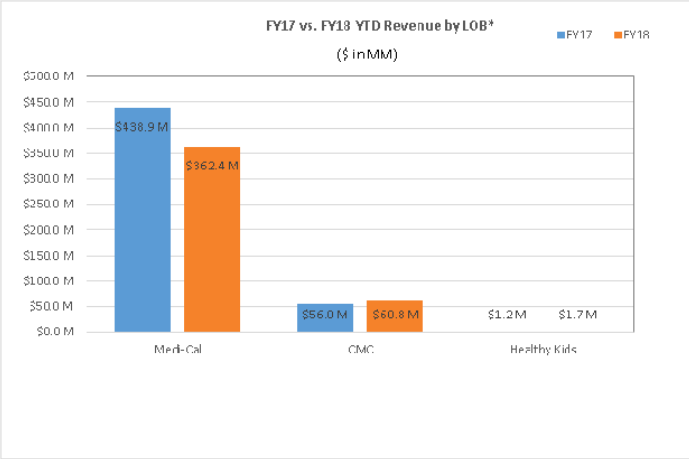
Santa Clara Family Health Plan Enrollment By Network
November 2018

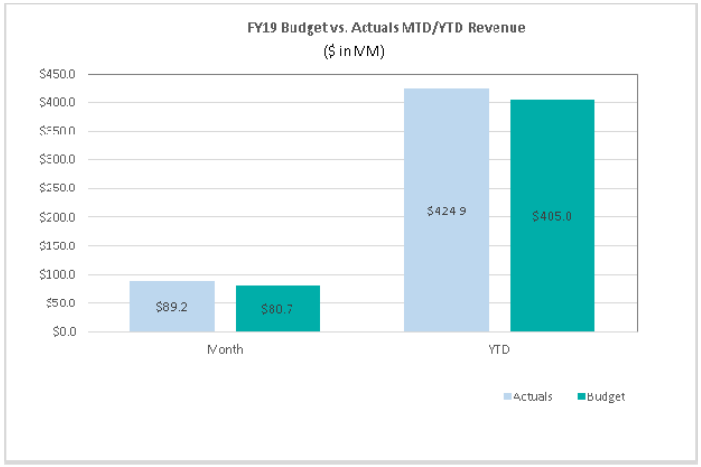
Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	29,892	12%	7,625	100%	386	11%	37,903	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	121,504	50%	-	0%	1,505	43%	123,009	48%
Palo Alto Medical Foundation	7,082	3%	-	0%	94	3%	7,176	3%
Physicians Medical Group	44,100	18%	-	0%	1,227	35%	45,327	18%
Premier Care	15,139	6%	-	0%	248	7%	15,387	6%
Kaiser	25,682	11%	-	0%	-	0%	25,682	10%
Total	**243,399**	**100%**	**7,625**	**100%**	**3,460**	**100%**	**254,484**	**100%**
Enrollment at June 30, 2018	248,776		7,503		3,196		259,475	
Net Δ from Beginning of FY19	-2.2%		1.6%		8.3%		-1.9%	

[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

Revenue

- Current month revenue of $89.2M is $8.5M or 10.5% favorable to budget of $80.7M. YTD revenue of $424.9M is $19.9M or 4.9% favorable to budget of $405.0M. This month's variances were due to several factors including:
  - Updated FY19 Prop 56 accrual increased revenue by $6.7M (with offsetting increase to medical expense).
  - Unbudgeted prior year retroactive revenue of $1.8M.
  - Updated FY19 MCO tax reduced revenue by $1.0M. MCO expense is anticipated to exceed MCO revenue by $2.0M for the fiscal year.





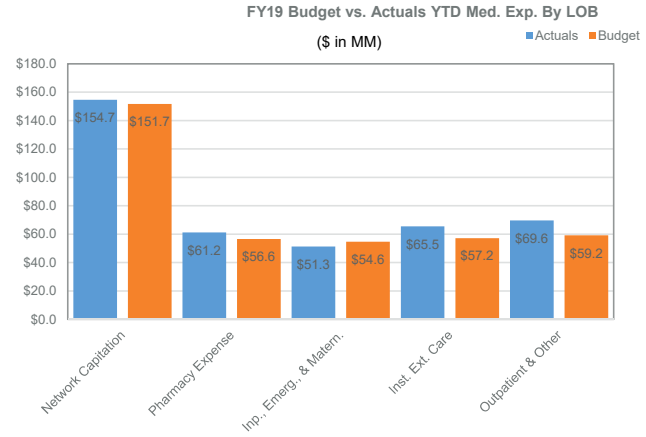
	FY17 vs. FY18 YTD Revenue by LOB*			
	FY17	FY18	Variance	
Medi-Cal	$438.9 M	$362.4 M	($76.5 M)	-17.4%
CMC	$56.0 M	$60.8 M	$4.8 M	8.5%
Healthy Kids	$1.2 M	$1.7 M	$0.5 M	40.3%
Total Revenue	**$496.1 M**	**$424.9 M**	**($66.4 M)**	**-13.4%**

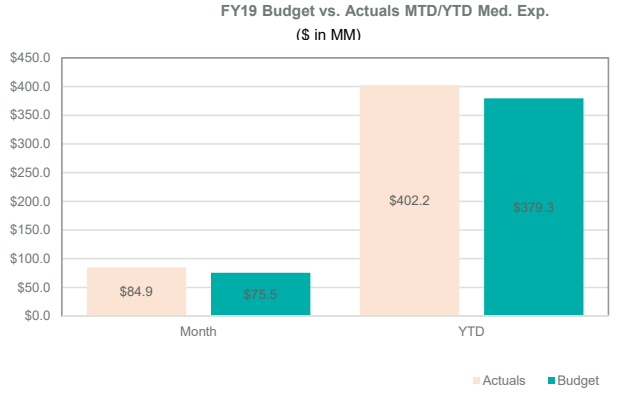
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$89.2	$80.7	$8.5	10.5%
YTD	$424.9	$405.0	$19.9	4.9%

**IHSS was included in FY18 revenue through 12/31/17*

Medical Expense

- Current month medical expense of $84.9M is $9.4M or 12.5% unfavorable to budget of $75.5M. YTD medical expense of $402.2M is $22.9M or 6.0% unfavorable to budget of $379.3M.The current month variances were due to a variety of factors, including:
  - Updated FY19 Prop 56 accrual increased medical expense by $6.7M (with offsetting increase to revenue).
  - Pharmacy costs exceeded budget by $1.0M due to an increased utilization, an increase in scripts/1,000, and a decrease in generics usage.
  - Increased Inpatient, Specialist Services, and Outpatient expenses contributed $1.7M to the unfavorable variance versus budget largely due to increased utilization.





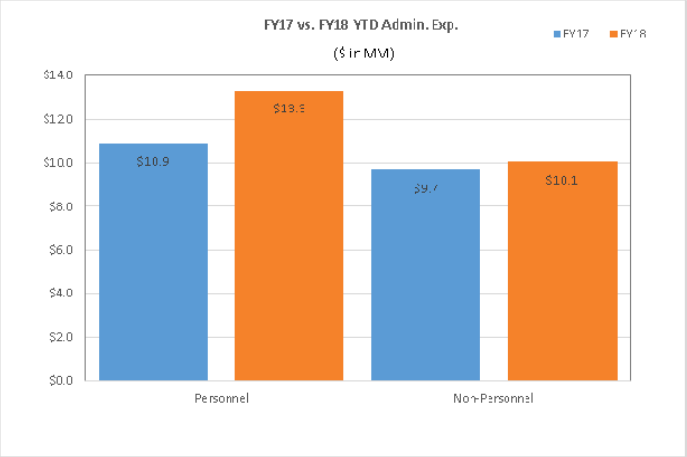
	FY19 Budget vs. Actuals YTD Med. Exp. By LOB			
	Actuals	Budget	Variance	
Network Capitation	$154.7	$151.7	-$2.9	-1.9%
Pharmacy	$61.2	$56.6	-$4.6	-7.5%
Inp., Emerg., & Matern.	$51.3	$54.6	$3.4	6.6%
Inst. Ext. Care	$65.5	$57.2	-$8.3	-12.7%
Outpatient & Other	$69.6	$59.2	-$10.4	-15.0%
Total Medical Expense	**$402.2**	**$379.3**	**-$22.9**	**-5.7%**

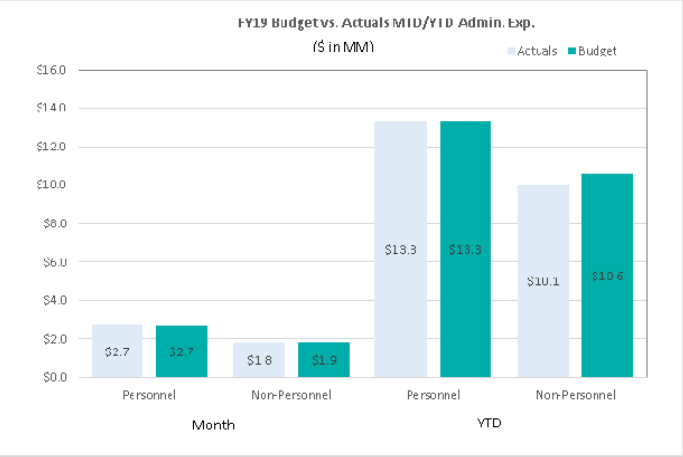
	FY19 Budget vs. Actuals MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$84.9	$75.5	$9.4	12.5%
YTD	$402.2	$379.3	$22.9	6.0%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month administrative expenses of $4.6M are at budget. YTD administrative expense of $23.4M is $0.6M or 2.3% favorable to budget of $23.9M.
  - Current month and YTD personnel expenses are at budget.
  - Consulting and temp staff expenses have seen an increase due to CMC program and data validation audits.
  - YTD postage and printing expenses are unfavorable due to timing differences.





	FY17 vs. FY18 YTD Admin. Exp.			
	FY17	FY18	Variance	
Personnel	$10.9	$13.3	$2.4	22.3%
Non-Personnel	$9.7	$10.1	$0.4	4.0%
Total Administrative Expense	**$20.6**	**$23.4**	**$2.8**	**13.7%**

		FY19 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.7	$2.7	$0.0	1.7%
	Non-Personnel	$1.8	$1.9	$0.0	-1.7%
	MTD Total	**$4.6**	**$4.6**	**$0.0**	**0.3%**
YTD	Personnel	$13.3	$13.3	$0.0	-0.1%
	Non-Personnel	$10.1	$10.6	-$0.5	-5.1%
	YTD Total	**$23.4**	**$23.9**	**-$0.6**	**-2.3%**

Balance Sheet

- Current assets totaled $744.4M compared to current liabilities of $595.9M, yielding a current ratio (Current Assets/Current Liabilities) of 1.25:1 vs. the DMHC minimum requirement of 1.0:1
- Cash as of November 30, 2018 decreased by -$5.0M compared to the cash balance as of year-end June 30, 2018 due to the timing of cash receipts and disbursements
- Current Cash & Equivalents components and interest yields were as follows:

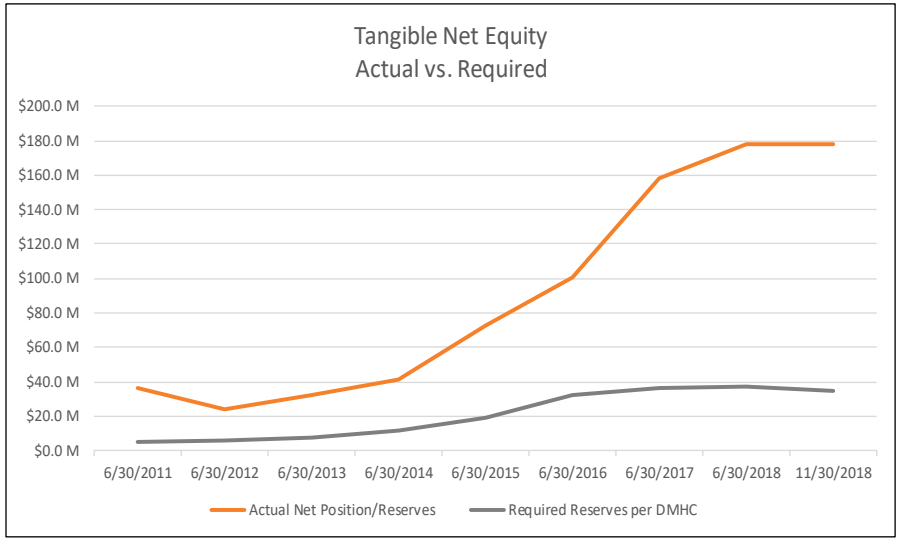
Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$77,910,740	1.29%	$100,000	$500,000
Cash & Equivalents				
Bank of the West Money Market	$245,151	1.12%	$10,143	$48,130
Wells Fargo Bank Accounts	$140,684,959	2.07%	$222,023	$1,000,063
	$140,930,110		$232,166	$1,048,193
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.08%	$13	$64
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$219,146,700**		**$332,179**	**$1,548,257**

Tangible Net Equity

- TNE was $178.2M or 511.2% of the most recent quarterly DMHC minimum requirement of $34.9M. TNE trends for SCFHP are shown below.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of: November 30, 2018

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	6/30/2018	11/30/2018
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$178.2 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$34.9 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$69.7 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	511.2%



Reserves Analysis

SCFHP RESERVES ANALYSIS November 2018	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	178,164,129
Current Required TNE	34,854,268
Excess TNE	**143,309,861**
Required TNE %	511.2%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	121,989,937
500% of Required TNE (High)	174,271,339
TNE Above/(Below) SCFHP Low Target	**$56,174,192**
TNE Above/(Below) High Target	**$3,892,790**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	219,146,700
Less Pass-Through Liabilities	
Net Payable to State of CA	-
Other Pass-Through Liabilities	(12,063,420)
Total Pass-Through Liabilities	**($12,063,420)**
Net Cash Available to SCFHP	$207,083,280
SCFHP Target Liability	
45 Days of Total Operating Expense	(120,210,934)
60 Days of Total Operating Expense	(160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$86,872,346**
Liquidity Above/(Below) High Target	**$46,802,035**

In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. Specific projects/recipients have yet to be determined.

Capital Expenditures

- YTD Capital investments of $4.5M, largely to complete the renovation of the new building, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
Building	$4,098,593	$7,874,631
Systems	0	925,000
Hardware	125,699	1,550,000
Software	277,000	593,000
Furniture and Fixtures	0	0
Automobile	0	0
Leasehold Improvements	0	0
TOTAL	**$4,501,292**	**$10,942,631**

** Includes FY18 budget rollover of $6,628,131*

Financial Statements

Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD NOV-18

		2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11
NON DUAL	Adult (over 19)	29,651	28,985	29,301	29,063	28,749	28,300	28,127	27,604	27,657	27,465	27,359	27,351	27,185	27,001	26,652	26,568	26,354	26,213
	Adult (under 19)	106,082	104,658	105,147	104,345	103,810	103,242	103,068	101,226	101,653	101,197	100,606	100,449	100,238	99,369	98,316	98,255	97,518	96,830
	Aged - Medi-Cal Only	10,674	10,776	10,693	10,722	10,801	10,778	10,781	10,892	10,906	10,906	10,924	10,891	10,963	10,909	10,815	10,887	10,869	10,887
	Disabled - Medi-Cal Only	10,979	10,965	10,903	10,888	10,880	10,875	10,843	10,807	10,825	10,786	10,801	10,750	10,750	10,742	10,679	10,635	10,611	10,624
	Adult Expansion	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971	73,959	73,601	73,398
	BCCTP	18	17	17	17	17	16	16	15	15	15	15	15	13	13	14	13	12	11
	Long Term Care	488	382	373	375	396	411	396	385	370	353	358	370	384	382	384	387	379	377
	Total Non-Duals	**240,241**	**236,083**	**237,175**	**235,880**	**234,651**	**232,854**	**232,438**	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**	**220,703**	**219,343**	**218,340**
DUAL	Adult (21 Over)	463	464	450	447	444	427	433	421	419	416	401	397	393	387	385	382	385	390
	Aged (21 Over)																		
	Disabled (21 Over)	23,010	22,906	23,299	23,412	23,452	23,433	23,331	23,300	23,405	23,312	22,969	23,064	22,811	22,919	22,928	22,984	22,963	22,897
	Adult Expansion	906	806	784	793	789	717	709	474	433	470	451	421	451	455	485	521	533	538
	BCCTP	1	1	1	1				1	1	2	2	2	2	2	2	2	1	1
	Long Term Care	1,132	1,131	1,162	1,169	1,182	1,202	1,195	1,209	1,155	1,118	1,117	1,159	1,295	1,316	1,323	1,292	1,268	1,233
	Total Duals	**25,512**	**25,308**	**25,696**	**25,822**	**25,867**	**25,779**	**25,668**	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**	**25,181**	**25,150**	**25,059**
	Total Medi-Cal	**265,753**	**261,391**	**262,871**	**261,702**	**260,518**	**258,633**	**258,106**	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**	**244,493**	**243,399**
	Healthy Kids	**2,732**	**2,633**	**2,618**	**2,243**	**2,288**	**2,321**	**2,447**	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**	**3,217**	**3,460**
CMC	CMC Non-Long Term Care	7,260	7,250	7,138	7,122	7,067	7,093	7,128	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318	7,386	7,383	7,407
	CMC - Long Term Care	283	275	267	261	259	256	261	257	255	256	241	237	228	221	222	214	218	218
	Total CMC	**7,543**	**7,525**	**7,405**	**7,383**	**7,326**	**7,349**	**7,389**	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**	**7,601**	**7,625**
	Total Enrollment	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**	**255,311**	**254,484**

Income Statement

Santa Clara Family Health Plan.

Santa Clara County Health Authority
Income Statement for Five Months Ending November 30, 2018

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 76,512,251	85.8%	$ 68,511,155	84.9%	$ 8,001,096	11.7%	$ 362,402,619	85.3%	$ 344,663,051	85.1%	$ 17,739,568	5.1%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,409,649	2.7%	2,517,204	3.1%	(107,556)	-4.3%	11,868,172	2.8%	12,454,145	3.1%	(585,973)	-4.7%
CMC MEDICARE	9,876,761	11.1%	9,372,225	11.6%	504,536	5.4%	48,885,365	11.5%	46,370,113	11.4%	2,515,253	5.4%
TOTAL CMC	12,286,410	13.8%	11,889,430	14.7%	396,981	3.3%	60,753,538	14.3%	58,824,258	14.5%	1,929,280	3.3%
HEALTHY KIDS	356,178	0.4%	302,245	0.4%	53,933	17.8%	1,745,728	0.4%	1,511,226	0.4%	234,502	15.5%
TOTAL REVENUE	**$ 89,154,840**	**100.0%**	**$ 80,702,830**	**100.0%**	**$ 8,452,010**	**10.5%**	**$ 424,901,885**	**100.0%**	**$ 404,998,534**	**100.0%**	**$ 19,903,350**	**4.9%**
MEDICAL EXPENSE												
MEDI-CAL	$ 73,497,523	82.4%	$ 63,952,918	79.2%	$ (9,544,605)	-14.9%	$ 340,972,306	80.2%	$ 322,412,777	79.6%	$ (18,559,529)	-5.8%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	*2,344,543*	*2.6%*	*2,207,756*	*2.7%*	*(136,787)*	*-6.2%*	*12,384,063*	*2.9%*	*10,923,117*	*2.7%*	*(1,460,946)*	*-13.4%*
CMC MEDICARE	*8,715,547*	*9.8%*	*9,023,495*	*11.2%*	*307,948*	*3.4%*	*47,179,020*	*11.1%*	*44,635,999*	*11.0%*	*(2,543,021)*	*-5.7%*
TOTAL CMC	11,060,090	12.4%	11,231,251	13.9%	171,162	1.5%	59,563,083	14.0%	55,559,116	13.7%	(4,003,967)	-7.2%
HEALTHY KIDS	348,075	0.4%	272,222	0.3%	(75,853)	-27.9%	1,682,460	0.4%	1,361,110	0.3%	(321,351)	-23.6%
TOTAL MEDICAL EXPENSES	**$ 84,905,688**	**95.2%**	**$ 75,456,392**	**93.5%**	**$ (9,449,296)**	**-12.5%**	**$ 402,217,849**	**94.7%**	**$ 379,333,003**	**93.7%**	**$ (22,884,846)**	**-6.0%**
MEDICAL OPERATING MARGIN	**$ 4,249,152**	**4.8%**	**$ 5,246,438**	**6.5%**	**$ (997,286)**	**-11.8%**	**$ 22,684,035**	**5.3%**	**$ 25,665,531**	**6.3%**	**$ (2,981,496)**	**-15.0%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,748,324	3.1%	$ 2,703,406	3.3%	$ (44,918)	-1.7%	$ 13,324,881	3.1%	$ 13,343,380	3.3%	$ 18,499	0.1%
RENTS AND UTILITIES	13,092	0.0%	17,611	0.0%	4,519	25.7%	273,064	0.1%	329,615	0.1%	56,552	17.2%
PRINTING AND ADVERTISING	34,952	0.0%	139,150	0.2%	104,198	74.9%	504,099	0.1%	462,750	0.1%	(41,349)	-8.9%
INFORMATION SYSTEMS	225,109	0.3%	226,473	0.3%	1,364	0.6%	973,279	0.2%	1,132,365	0.3%	159,087	14.0%
PROF FEES/CONSULTING/TEMP STAFFING	913,999	1.0%	820,480	1.0%	(93,519)	-11.4%	5,385,041	1.3%	4,694,415	1.2%	(690,625)	-14.7%
DEPRECIATION/INSURANCE/EQUIPMENT	397,915	0.4%	457,566	0.6%	59,652	13.0%	1,832,191	0.4%	2,316,332	0.6%	484,141	20.9%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	74,690	0.1%	73,930	0.1%	(760)	-1.0%	513,945	0.1%	954,918	0.2%	440,972	46.2%
MEETINGS/TRAVEL/DUES	83,653	0.1%	98,176	0.1%	14,524	14.8%	424,131	0.1%	551,788	0.1%	127,657	23.1%
OTHER	76,429	0.1%	17,804	0.0%	(58,625)	-329.3%	153,654	0.0%	158,603	0.0%	4,949	3.1%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,568,163**	**5.1%**	**$ 4,554,597**	**5.6%**	**$ (13,566)**	**-0.3%**	**$ 23,384,284**	**5.5%**	**$ 23,944,166**	**5.9%**	**$ 559,882**	**2.3%**
OPERATING SURPLUS (LOSS)	$ (319,011)	-0.4%	$ 691,841	0.9%	$ (1,010,852)	-146.1%	$ (700,249)	-0.2%	$ 1,721,365	0.4%	$ (2,421,614)	-140.7%
OTHER INCOME/EXPENSE												
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(298,898)	-0.1%	(298,900)	-0.1%	2	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(375,000)	-0.1%	(375,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	353,916	0.4%	47,605	0.1%	306,311	643.4%	1,522,413	0.4%	238,025	0.1%	1,284,389	539.6%
OTHER INCOME/EXPENSE	**219,137**	**0.2%**	**(87,175)**	**-0.1%**	**306,312**	**-351.4%**	**848,515**	**0.2%**	**(435,875)**	**-0.1%**	**1,284,390**	**-294.7%**
NET SURPLUS (LOSS)	**$ (99,874)**	**-0.1%**	**$ 604,666**	**0.7%**	**$ (704,541)**	**-116.5%**	**$ 148,266**	**0.0%**	**$ 1,285,490**	**0.3%**	**$ (1,137,224)**	**-88.5%**

Balance Sheet

Assets	November 2018	October 2018	September 2018	June 2018
Current Assets				
Cash and Marketable Securities	$219,146,700	$210,241,106	$233,279,977	$224,156,209
Receivables	516,509,111	507,221,511	501,964,866	493,307,425
Prepaid Expenses and Other Current Assets	8,790,259	8,811,521	7,176,276	7,024,982
Total Current Assets	**744,446,070**	**726,274,138**	**742,421,119**	**724,488,615**
Long Term Assets				
Property and Equipment	43,080,423	42,947,276	42,357,057	38,579,130
Accumulated Depreciation	(15,859,845)	(15,535,421)	(15,212,360)	(14,309,761)
Total Long Term Assets	27,220,578	27,411,855	27,144,697	24,269,369
Total Assets	**771,666,648**	**753,685,993**	**769,565,816**	**748,757,984**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**14,535,240**	**14,535,240**
Total Deferred Outflows and Assets	**786,201,888**	**768,221,233**	**784,101,056**	**763,293,224**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	8,265,839	5,327,669	5,194,835	8,351,090
Deferred Rent	(0)	(0)	(0)	17,011
Employee Benefits	1,668,438	1,599,737	1,584,704	1,473,524
Retirement Obligation per GASB 45	5,181,693	5,121,914	5,062,134	4,882,795
Advance Premium - Healthy Kids	82,523	80,686	87,424	66,195
Deferred Revenue - Medicare	8,943,810	-	-	9,928,268
Whole Person Care/Prop 56	12,063,420	7,896,914	7,324,264	9,263,004
Payable to Hospitals	-	-	-	0
Due to Santa Clara County Valley Health Plan and Kaiser	9,163,650	9,213,279	11,186,460	6,691,979
MCO Tax Payable - State Board of Equalization	17,569,260	8,784,631	27,231,162	(0)
Due to DHCS	30,744,662	28,225,971	30,997,453	24,429,978
Liability for In Home Support Services (IHSS)	413,549,552	413,549,552	413,549,552	413,549,551
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	86,276,451	95,703,417	89,491,100	92,470,504
Total Current Liabilities	**595,883,823**	**577,878,294**	**594,083,611**	**573,498,425**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	2,199,796	2,124,796	2,049,796	1,824,796
Total Non-Current Liabilities	**8,119,296**	**8,044,296**	**7,969,296**	**7,744,296**
Total Liabilities	**604,003,119**	**585,922,590**	**602,052,907**	**581,242,721**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**4,034,640**	**4,034,640**
Net Assets / Reserves				
Invested in Capital Assets	27,220,578	27,411,855	27,144,697	24,269,369
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	150,489,935	150,298,658	150,565,816	133,805,841
Current YTD Income (Loss)	148,266	248,141	(2,354)	19,635,303
Total Net Assets / Reserves	178,164,129	178,264,003	178,013,509	178,015,863
Total Liabilities, Deferred Inflows, and Net Assets	**786,201,888**	**768,221,233**	**784,101,056**	**763,293,224**

Cash Flow – YTD

Cash Flows from Operating Activities	
Premiums Received	425,584,143
Medical Expenses Paid	(405,940,231)
Adminstrative Expenses Paid	(21,674,541)
Net Cash from Operating Activities	**($2,030,629)**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(4,501,293)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	1,522,413
Net Increase/(Decrease) in Cash & Cash Equivalents	**(5,009,509)**
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Nov 18)	**$219,146,700**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**$148,266**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	1,550,084
Changes in Operating Assets/Liabilities	
Premiums Receivable	(23,201,686)
Other Receivable	(1,522,413)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(1,765,278)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	2,223,835
State Payable	23,883,944
Santa Clara Valley Health Plan & Kaiser Payable	2,471,671
Net Pension Liability	375,000
Medical Cost Reserves & PDR	(6,194,053)
IHSS Payable	0
Deferred Inflow of Resources	-
Total Adjustments	**($3,728,980)**
Net Cash from Operating Activities	**($2,030,629)**

Statement of Operations - YTD

Santa Clara Family Health Plan.

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Five Months Ending November 30 2018

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 362,402,619	$ 11,868,172	$ 48,885,365	$ 60,753,538	$ 1,745,728	**$ 424,901,885**
MEDICAL EXPENSE	$ 340,972,306	$ 12,384,063	$ 47,179,020	$ 59,563,083	$ 1,682,460	**$ 402,217,849**
(MLR)	94.1%	104.3%	96.5%	98.0%	96.4%	**94.7%**
GROSS MARGIN	$ 21,430,313	$ (515,891)	$ 1,706,345	$ 1,190,454	$ 63,267	**$ 22,684,035**
ADMINISTRATIVE EXPENSE	$ 19,944,665	$ 653,160	$ 2,690,384	$ 3,343,544	$ 96,075	**$ 23,384,284**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 1,485,648	$ (1,169,050)	$ (984,039)	$ (2,153,089)	$ (32,808)	**$ (700,249)**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 723,706	$ 23,700	$ 97,622	$ 121,323	$ 3,486	**$ 848,515**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 2,209,354	$ (1,145,350)	$ (886,417)	$ (2,031,766)	$ (29,322)	**$ 148,266**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 295.24	$ 334.49	$ 1,290.23	$ 1,603.46	$ 107.07	**$ 331.52**
MEDICAL EXPENSES	$ 277.78	$ 349.03	$ 1,245.19	$ 1,572.04	$ 103.19	**$ 313.82**
GROSS MARGIN	$ 17.46	$ (14.54)	$ 45.04	$ 31.42	$ 3.88	**$ 17.70**
ADMINISTRATIVE EXPENSES	$ 16.25	$ 18.41	$ 71.01	$ 88.25	$ 5.89	**$ 18.25**
OPERATING INCOME/(LOSS)	$ 1.21	$ (32.95)	$ (25.97)	$ (56.83)	$ (2.01)	**$ (0.55)**
OTHER INCOME/(EXPENSE)	$ 0.59	$ 0.67	$ 2.58	$ 3.20	$ 0.21	**$ 0.66**
NET INCOME/(LOSS)	$ 1.80	$ (32.28)	$ (23.40)	$ (53.62)	$ (1.80)	**$ 0.12**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	1,227,485	35,481	37,889	37,889	16,305	1,281,679
REVENUE BY LOB	85.3%	2.8%	11.5%	14.3%	0.4%	100.0%

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Six Months Ended December 31, 2018

Agenda

Santa Clara Family Health Plan.

Financial Highlights

	MTD		YTD	
Revenue	$91 M		$516 M	
Medical Expense (MLR)	$79 M	86.8%	$481 M	93.3%
Administrative Expense (% Rev)	$4.3 M	4.8%	$27.7 M	5.4%
Other Income/Expense	$253,037		$1,101,552	
Net Surplus (Loss)	**$7,908,295**		**$8,056,809**	
Cash on Hand			$208 M	
Net Cash Available to SCFHP			$194 M	
Receivables			$535 M	
Total Current Assets			$751 M	
Current Liabilities			$595 M	
Current Ratio			1.26	
Tangible Net Equity			$186 M	
% of DMHC Requirements			**537.4%**	

Financial Highlights

Net Surplus (Loss)	Month: Surplus of $7.9M is $7.1M or 879.7% favorable to budget of $0.8M. YTD: Surplus of $8.1M is $6.0M or 285.0% favorable to budget of $2.1M.
Enrollment	Month: Membership was 253,735 (917 or 0.4% favorable budget of 252,818). YTD: Member months was 1.5M (2.0K or 0.1% favorable budget of 1.5M).
Revenue	Month: $91.2M ($10.6M or 13.2% favorable to budget of $80.6M) YTD: $516.1M ($30.5M or 6.3% favorable to budget of $485.6M)
Medical Expenses	Month: $79.2M (-$3.9M or -5.2% unfavorable to budget of $75.3M) YTD: $481.4M (-$26.8M or -5.9% unfavorable to budget of $454.6M)
Administrative Expenses	Month: $4.3M ($66.6K or 1.5% favorable to budget of $4.4M) YTD: $27.7M ($0.6M or 2.2% favorable to budget of $28.4M)
Tangible Net Equity	December 2018 TNE was $186.1M (537.4% of minimum DMHC requirement of $34.6M)
Capital Expenditures	YTD Capital Investment of $5.0M vs. $10.9M annual budget was primarily due to building renovation.

Detail Analyses

Enrollment

- Total enrollment has decreased since June 30, 2018 by 5,740 members or -2.2%.
- As detailed on page 15, much of the Medi-Cal enrollment decline has been in the Medi-Cal Non-Dual Adult and Child categories of aid. Medi-Cal Dual enrollment has stabilized while CMC enrollment has grown due to outreach efforts.
- FY19 Membership Trends:
  - Medi-Cal membership has decreased since the beginning of the fiscal year by -2.4%. Over the past 12 months, enrollment has decreased 6.0%.
  - CMC membership increased since the beginning of the fiscal year by 2.6%. Over the past 12 months, enrollment has increased 4.1%.
  - Healthy Kids membership increased since the beginning of the fiscal year by 4.7%. Over the past 12 months, enrollment has increased 36.7%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of December 2018			For Six Months Ending December 31 2018				
	Actual	Budget	Variance	Actual	Budget	Variance	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	242,695	242,219	0.2%	1,470,180	1,470,542	-(0.0%)	1,563,220	-(6.0%)
Healthy Kids	3,345	2,924	14.4%	19,650	17,469	12.5%	14,550	35.1%
Medicare	7,695	7,675	0.3%	45,584	45,450	0.3%	44,377	2.7%
Total	**253,735**	**252,818**	**0.4%**	**1,535,414**	**1,533,461**	**0.1%**	**1,622,147**	**-(5.3%)**

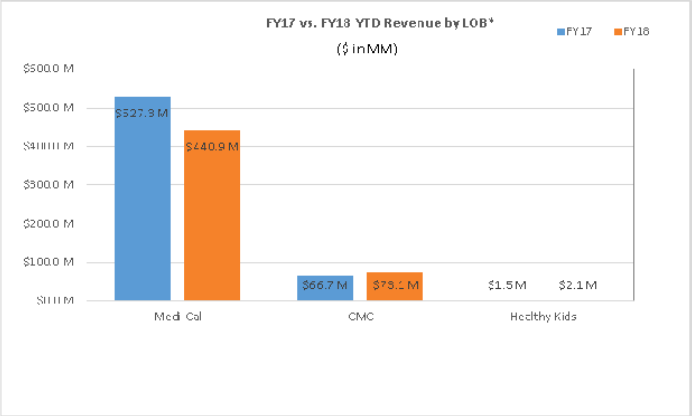
Santa Clara Family Health Plan Enrollment By Network
December 2018

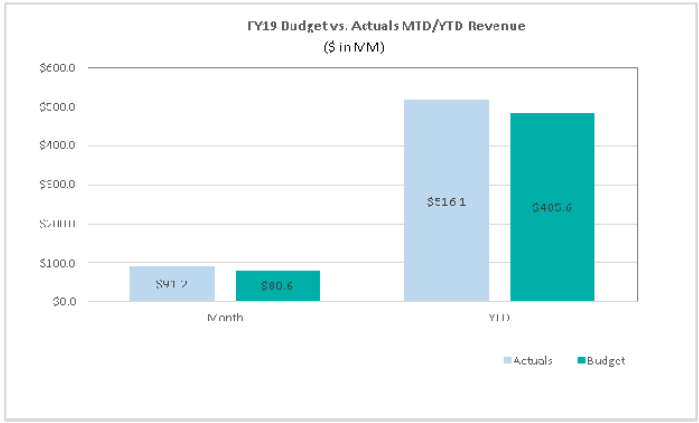
Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	30,083	12%	7,695	100%	382	11%	38,160	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	121,113	50%	-	0%	1,441	43%	122,554	48%
Palo Alto Medical Foundation	7,055	3%	-	0%	89	3%	7,144	3%
Physicians Medical Group	43,866	18%	-	0%	1,200	36%	45,066	18%
Premier Care	15,110	6%	-	0%	233	7%	15,343	6%
Kaiser	25,468	10%	-	0%	-	0%	25,468	10%
Total	**242,695**	**100%**	**7,695**	**100%**	**3,345**	**100%**	**253,735**	**100%**
Enrollment at June 30, 2018	248,776		7,503		3,196		259,475	
Net Δ from Beginning of FY19	-2.4%		2.6%		4.7%		-2.2%	

[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

Revenue

- Current month revenue of $91.2M is $10.6M or 13.2% favorable to budget of $80.6M. YTD revenue of $516.1M is $30.5M or 6.3% favorable to budget of $485.6M. This month's variances were due to several factors including:
  - Retroactive adjustments of $7.6M received from DHCS for HCBS High and Low CY18 revenue.
  - Updated FY19 Prop 56 accrual increased revenue by $1.8M (with offsetting increase to medical expense).
  - Increased BHT & Maternity kick revenue of $1.3M.
  - Updated FY19 MCO rates reduced revenue by $100K. MCO expense is expected to exceed MCO revenue by $2.0 for the fiscal year.





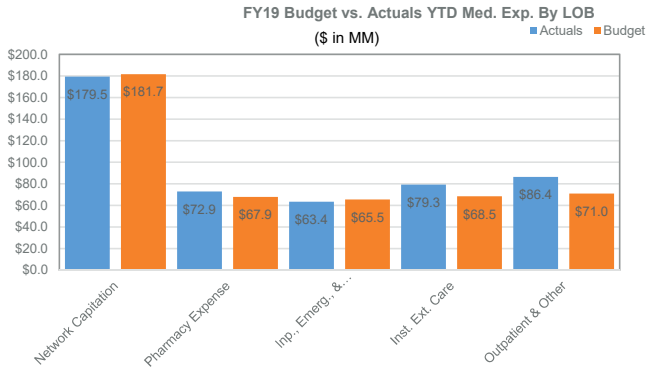
	FY17 vs. FY18 YTD Revenue by LOB*			
	FY17	FY18	Variance	
Medi-Cal	$527.3 M	$440.9 M	($86.4 M)	-16.4%
CMC	$66.7 M	$73.1 M	$6.4 M	9.6%
Healthy Kids	$1.5 M	$2.1 M	$0.6 M	39.7%
Total Revenue	**$595.5 M**	**$516.1 M**	**($73.0 M)**	**-12.3%**

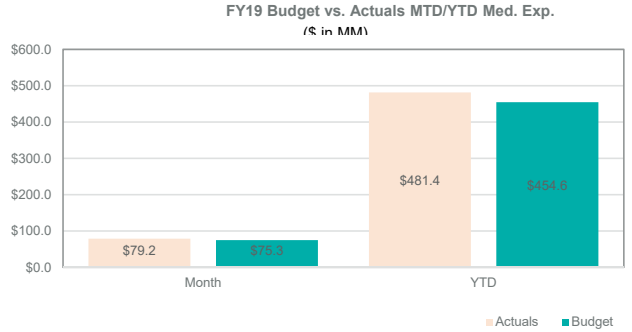
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$91.2	$80.6	$10.6	13.2%
YTD	$516.1	$485.6	$30.5	6.3%

IHSS was included in FY18 revenue through 12/31/17

Medical Expense

- Current month medical expense of $79.2M is $3.9M or 5.2% unfavorable to budget of $75.3M. YTD medical expense of $481.4M is $26.8M or 5.9% unfavorable to budget of $454.6M.The current month variances were due to a variety of factors, including:
  - Increased Inpatient, Outpatient, Maternity and LTC expenses yielded an unfavorable variance of $5.2M
  - Pharmacy costs exceeded budget by $400K due to increased utilization and decreased generics usage.
  - Partially offsetting the above items, capitation expense was under budget by $5M due to retroactive clawbacks.





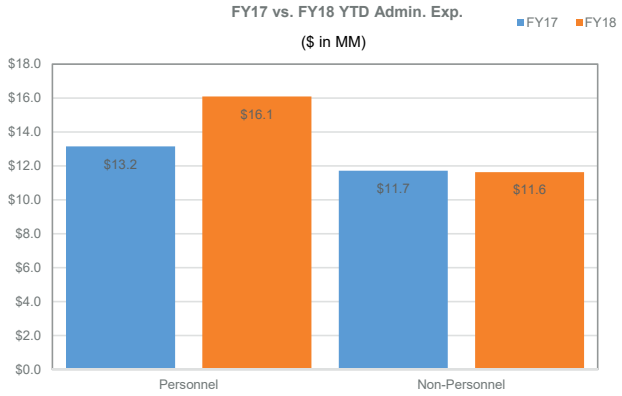
FY19 Budget vs. Actuals YTD Med. Exp. By LOB				
	Actuals	Budget	Variance	
Network Capitation	$179.5	$181.7	$2.2	1.2%
Pharmacy	$72.9	$67.9	-$5.0	-6.9%
Inp., Emerg., & Matern.	$63.4	$65.5	$2.2	3.4%
Inst. Ext. Care	$79.3	$68.5	-$10.7	-13.6%
Outpatient & Other	$86.4	$71.0	-$15.4	-17.8%
Total Medical Expense	**$481.4**	**$454.6**	**-$26.8**	**-5.6%**

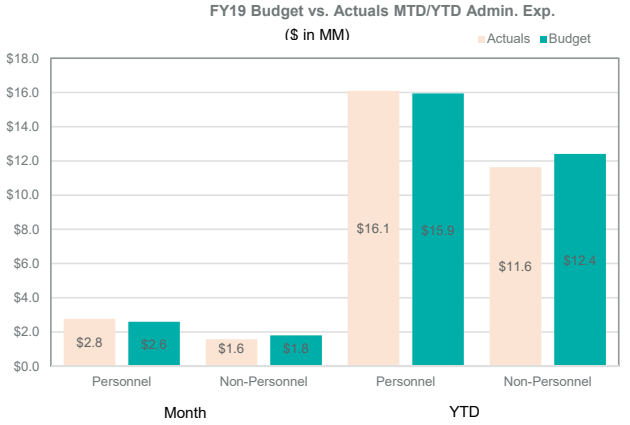
FY19 Budget vs. Actuals MTD/YTD Med. Exp.				
	Actuals	Budget	Variance	
Month	$79.2	$75.3	$3.9	5.2%
YTD	$481.4	$454.6	$26.8	5.9%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month admin expense of $4.3M is $66.6K or -1.5% favorable to budget of $4.4M. YTD admin expense of $27.7M is $0.6M or -2.2% favorable to budget of $28.4M. The current month variances were due to a variety of factors, including:
  - Personnel expenses were 0.9% over budget due to the timing of hiring staff.
  - Consultants and temp staff expense have seen an increase due to the CMC program and data validation audits.
  - Printing and postage are favorable to the YTD budget due to timing of expenses.





	FY17 vs. FY18 YTD Admin. Exp.			
	FY17	FY18	Variance	
Personnel	$13.2	$16.1	$2.9	22.4%
Non-Personnel	$11.7	$11.6	-$0.1	-0.7%
Total Administrative Expense	**$24.9**	**$27.7**	**$2.9**	**11.5%**

		FY19 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.8	$2.6	$0.2	6.4%
	Non-Personnel	$1.6	$1.8	-$0.2	-12.8%
	MTD Total	**$4.3**	**$4.4**	**-$0.1**	**-1.5%**
YTD	Personnel	$16.1	$15.9	$0.1	0.9%
	Non-Personnel	$11.6	$12.4	-$0.8	-6.2%
	YTD Total	**$27.7**	**$28.4**	**-$0.6**	**-2.2%**

Balance Sheet

- Current assets totaled $751.3M compared to current liabilities of $594.9M, yielding a current ratio (Current Assets/Current Liabilities) of 1.26:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash as of December 31, 2018 decreased by -$16.1M compared to the cash balance as of year-end June 30, 2018.
- Current Cash & Equivalents components and yields were as follows:

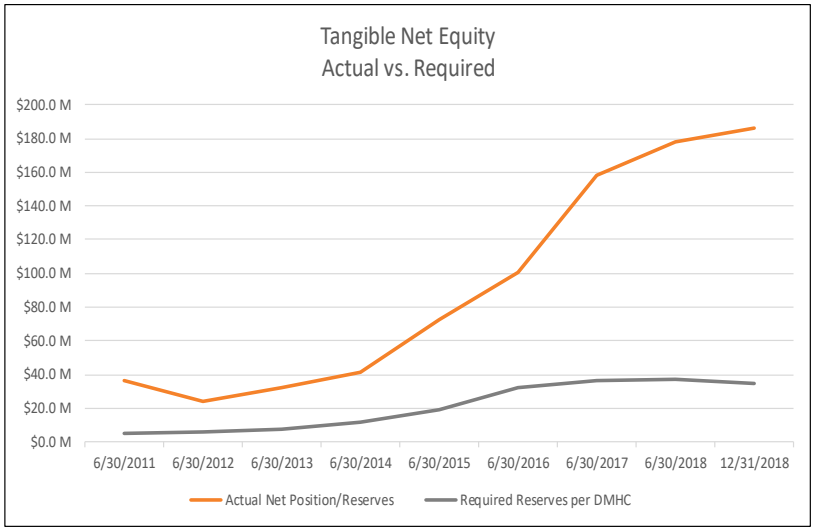
Description	Month-End Balance	Current Yield %	Interest Accrued	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$77,910,740	1.29%	$100,000	$600,000
Cash & Equivalents				
Bank of the West Money Market	$97,148	1.12%	$2,497	$50,627
Wells Fargo Bank Accounts	$129,712,344	2.35%	$270,745	$1,270,808
	$129,809,492		$273,242	$1,321,435
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	$0	$64
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$208,026,081**		**$373,242**	**$1,921,499**

Tangible Net Equity

- TNE was $186.1M in December 2018 or 537.4% of the most recent quarterly DMHC minimum requirement of $34.6M. TNE trends for SCFHP are shown below.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of: December 31, 2018

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	6/30/2018	12/31/2018
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$186.1 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$34.6 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$69.3 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	537.4%



Reserves Analysis

SCFHP RESERVES ANALYSIS December 2018	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	186,072,672
Current Required TNE	34,625,948
Excess TNE	**151,446,724**
Required TNE %	537.4%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	121,190,817
500% of Required TNE (High)	173,129,739
TNE Above/(Below) SCFHP Low Target	**$64,881,855**
TNE Above/(Below) High Target	**$12,942,933**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	208,026,081
Less Pass-Through Liabilities	
Net Payable to State of CA	-
Other Pass-Through Liabilities	(13,847,960)
Total Pass-Through Liabilities	**($13,847,960)**
Net Cash Available to SCFHP	$194,178,121
SCFHP Target Liability	
45 Days of Total Operating Expense	(120,210,934)
60 Days of Total Operating Expense	(160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$73,967,187**
Liquidity Above/(Below) High Target	**$33,896,876**

In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. The specific projects/recipients have yet to be determined.

Capital Expenditures

- YTD Capital investments of $5M, largely to complete the renovation of the new building, were comprised of the following:

Expenditure	YTD Actual	Annual Budget
New Building	$4,563,854	$ 7,874,631.00
Systems	0	925,000
Hardware	134,415	1,550,000
Software	277,000	593,000
Furniture and Fixtures	0	0
Automobile	0	0
Leasehold Improvements	0	0
TOTAL	**$4,975,269**	**$10,942,631**

** Includes FY18 budget rollover of $6,628,131*

Financial Statements

Enrollment By Aid Category

SCFHP TRENDED ENROLLMENT BY COA YTD DEC-18

		2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12
NON DUAL	Adult (over 19)	29,651	28,985	29,301	29,063	28,749	28,300	28,127	27,604	27,657	27,465	27,359	27,351	27,185	27,001	26,652	26,568	26,354	26,213	26,175
	Adult (under 19)	106,082	104,658	105,147	104,345	103,810	103,242	103,068	101,226	101,653	101,197	100,606	100,449	100,238	99,369	98,316	98,255	97,518	96,830	96,330
	Aged - Medi-Cal Only	10,674	10,776	10,693	10,722	10,801	10,778	10,781	10,892	10,906	10,906	10,924	10,891	10,963	10,909	10,815	10,887	10,869	10,887	10,923
	Disabled - Medi-Cal Only	10,979	10,965	10,903	10,888	10,880	10,875	10,843	10,807	10,825	10,786	10,801	10,750	10,750	10,742	10,679	10,635	10,611	10,624	10,631
	Adult Expansion	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971	73,959	73,601	73,398	73,186
	BCCTP	18	17	17	17	17	16	16	15	15	15	15	15	13	13	14	13	12	11	11
	Long Term Care	488	382	373	375	396	411	396	385	370	353	358	370	384	382	384	387	379	377	372
	Total Non-Duals	**240,241**	**236,083**	**237,175**	**235,880**	**234,651**	**232,854**	**232,438**	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**	**220,703**	**219,343**	**218,340**	**217,628**
DUAL	Adult (21 Over)	463	464	450	447	444	427	433	421	419	416	401	397	393	387	385	382	385	390	379
	Aged (21 Over)																			
	Disabled (21 Over)	23,010	22,906	23,299	23,412	23,452	23,433	23,331	23,300	23,405	23,312	22,969	23,064	22,811	22,919	22,928	22,984	22,963	22,897	22,893
	Adult Expansion	906	806	784	793	789	717	709	474	433	470	451	421	451	455	485	521	533	538	586
	BCCTP	1	1	1	1				1	1	2	2	2	2	2	2	2	1	1	1
	Long Term Care	1,132	1,131	1,162	1,169	1,182	1,202	1,195	1,209	1,155	1,118	1,117	1,159	1,295	1,316	1,323	1,292	1,268	1,233	1,208
	Total Duals	**25,512**	**25,308**	**25,696**	**25,822**	**25,867**	**25,779**	**25,668**	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**	**25,181**	**25,150**	**25,059**	**25,067**
	Total Medi-Cal	**265,753**	**261,391**	**262,871**	**261,702**	**260,518**	**258,633**	**258,106**	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**	**244,493**	**243,399**	**242,695**
	Healthy Kids	**2,732**	**2,633**	**2,618**	**2,243**	**2,288**	**2,321**	**2,447**	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**	**3,217**	**3,460**	**3,345**
CMC	CMC Non-Long Term Care	7,260	7,250	7,138	7,122	7,067	7,093	7,128	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318	7,386	7,383	7,407	7,484
	CMC - Long Term Care	283	275	267	261	259	256	261	257	255	256	241	237	228	221	222	214	218	218	211
	Total CMC	**7,543**	**7,525**	**7,405**	**7,383**	**7,326**	**7,349**	**7,389**	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**	**7,601**	**7,625**	**7,695**
	Total Enrollment	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**	**255,311**	**254,484**	**253,735**

Income Statement

Santa Clara Family Health Plan.

Santa Clara County Health Authority
Income Statement for Six Months Ending December 31, 2018

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 78,501,095	86.1%	$ 68,303,739	84.8%	$ 10,197,357	14.9%	$ 440,903,715	85.4%	$ 412,966,790	85.0%	$ 27,936,925	6.8%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,422,984	2.7%	2,530,392	3.1%	(107,408)	-4.2%	14,291,156	2.8%	14,984,537	3.1%	(693,381)	-4.6%
CMC MEDICARE	9,906,672	10.9%	9,421,327	11.7%	485,345	5.2%	58,792,037	11.4%	55,791,439	11.5%	3,000,598	5.4%
TOTAL CMC	12,329,655	13.5%	11,951,719	14.8%	377,937	3.2%	73,083,193	14.2%	70,775,977	14.6%	2,307,216	3.3%
HEALTHY KIDS	346,077	0.4%	303,804	0.4%	42,274	13.9%	2,091,805	0.4%	1,815,029	0.4%	276,776	15.2%
TOTAL REVENUE	**$ 91,176,828**	**100.0%**	**$ 80,559,261**	**100.0%**	**$ 10,617,567**	**13.2%**	**$ 516,078,713**	**100.0%**	**$ 485,557,795**	**100.0%**	**$ 30,520,917**	**6.3%**
MEDICAL EXPENSE												
MEDI-CAL	$ 66,215,138	72.6%	$ 63,691,720	79.1%	$ (2,523,418)	-4.0%	$ 407,187,444	78.9%	$ 386,104,497	79.5%	$ (21,082,947)	-5.5%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	*2,492,588*	*2.7%*	*2,219,323*	*2.8%*	*(273,265)*	*-12.3%*	*14,876,651*	*2.9%*	*13,142,439*	*2.7%*	*(1,734,212)*	*-13.2%*
CMC MEDICARE	*10,154,326*	*11.1%*	*9,071,643*	*11.3%*	*(1,082,684)*	*-11.9%*	*57,333,347*	*11.1%*	*53,707,642*	*11.1%*	*(3,625,705)*	*-6.8%*
TOTAL CMC	12,646,915	13.9%	11,290,965	14.0%	(1,355,949)	-12.0%	72,209,998	14.0%	66,850,081	13.8%	(5,359,916)	-8.0%
HEALTHY KIDS	317,524	0.3%	273,626	0.3%	(43,898)	-16.0%	1,999,984	0.4%	1,634,736	0.3%	(365,249)	-22.3%
TOTAL MEDICAL EXPENSES	**$ 79,179,576**	**86.8%**	**$ 75,256,311**	**93.4%**	**$ (3,923,265)**	**-5.2%**	**$ 481,397,426**	**93.3%**	**$ 454,589,314**	**93.6%**	**$ (26,808,112)**	**-5.9%**
MEDICAL OPERATING MARGIN	**$ 11,997,252**	**13.2%**	**$ 5,302,950**	**6.6%**	**$ 6,694,302**	**63.0%**	**$ 34,681,287**	**6.7%**	**$ 30,968,481**	**6.4%**	**$ 3,712,806**	**12.2%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,765,007	3.0%	$ 2,599,112	3.2%	$ (165,894)	-6.4%	$ 16,089,887	3.1%	$ 15,942,492	3.3%	$ (147,395)	-0.9%
RENTS AND UTILITIES	12,064	0.0%	17,611	0.0%	5,547	31.5%	285,128	0.1%	347,226	0.1%	62,099	17.9%
PRINTING AND ADVERTISING	12,939	0.0%	70,150	0.1%	57,211	81.6%	517,038	0.1%	532,900	0.1%	15,862	3.0%
INFORMATION SYSTEMS	133,082	0.1%	226,473	0.3%	93,391	41.2%	1,106,360	0.2%	1,358,839	0.3%	252,478	18.6%
PROF FEES/CONSULTING/TEMP STAFFING	897,019	1.0%	805,522	1.0%	(91,497)	-11.4%	6,281,812	1.2%	5,499,937	1.1%	(781,875)	-14.2%
DEPRECIATION/INSURANCE/EQUIPMENT	379,987	0.4%	457,566	0.6%	77,580	17.0%	2,212,178	0.4%	2,773,898	0.6%	561,720	20.3%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	23,368	0.0%	119,005	0.1%	95,637	80.4%	537,313	0.1%	1,073,922	0.2%	536,609	50.0%
MEETINGS/TRAVEL/DUES	101,328	0.1%	95,346	0.1%	(5,981)	-6.3%	525,459	0.1%	647,134	0.1%	121,675	18.8%
OTHER	17,201	0.0%	17,804	0.0%	603	3.4%	170,855	0.0%	176,407	0.0%	5,552	3.1%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,341,993**	**4.8%**	**$ 4,408,590**	**5.5%**	**$ 66,597**	**1.5%**	**$ 27,726,030**	**5.4%**	**$ 28,352,756**	**5.8%**	**$ 626,726**	**2.2%**
OPERATING SURPLUS (LOSS)	$ 7,655,258	8.4%	$ 894,360	1.1%	$ 6,760,898	755.9%	$ 6,955,257	1.3%	$ 2,615,725	0.5%	$ 4,339,532	165.9%
OTHER INCOME/EXPENSE												
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(358,678)	-0.1%	(358,680)	-0.1%	2	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(450,000)	-0.1%	(450,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	387,816	0.4%	47,605	0.1%	340,211	714.7%	1,910,230	0.4%	285,630	0.1%	1,624,600	568.8%
OTHER INCOME/EXPENSE	**253,037**	**0.3%**	**(87,175)**	**-0.1%**	**340,212**	**-390.3%**	**1,101,552**	**0.2%**	**(523,050)**	**-0.1%**	**1,624,602**	**-310.6%**
NET SURPLUS (LOSS)	**$ 7,908,295**	**8.7%**	**$ 807,185**	**1.0%**	**$ 7,101,110**	**879.7%**	**$ 8,056,809**	**1.6%**	**$ 2,092,675**	**0.4%**	**$ 5,964,134**	**285.0%**

Balance Sheet

Assets	December 2018	November 2018	October 2018	June 2018
Current Assets				
Cash and Marketable Securities	$208,026,081	$219,146,700	$210,241,106	$224,156,209
Receivables	534,641,224	516,509,111	507,221,511	493,307,425
Prepaid Expenses and Other Current Assets	8,623,739	8,790,259	8,811,521	7,024,982
Total Current Assets	**751,291,045**	**744,446,070**	**726,274,138**	**724,488,615**
Long Term Assets				
Property and Equipment	43,554,399	43,080,423	42,947,276	38,579,130
Accumulated Depreciation	(16,186,309)	(15,859,845)	(15,535,421)	(14,309,761)
Total Long Term Assets	27,368,090	27,220,578	27,411,855	24,269,369
Total Assets	**778,659,134**	**771,666,648**	**753,685,993**	**748,757,984**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**14,535,240**	**14,535,240**
Total Deferred Outflows and Assets	**793,194,374**	**786,201,888**	**768,221,233**	**763,293,224**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	3,986,497	8,265,592	5,327,669	8,351,090
Deferred Rent	(0)	(0)	(0)	17,011
Employee Benefits	1,725,742	1,668,438	1,599,737	1,473,524
Retirement Obligation per GASB 45	3,909,473	5,181,693	5,121,914	4,882,795
Advance Premium - Healthy Kids	78,886	82,523	80,686	66,195
Deferred Revenue - Medicare	-	8,943,810	-	9,928,268
Whole Person Care/Prop 56	13,847,960	12,063,420	7,896,914	9,263,004
Payable to Hospitals	-	-	-	0
Due to Santa Clara County Valley Health Plan and Kaiser	10,370,443	9,163,650	9,213,279	6,691,979
MCO Tax Payable - State Board of Equalization	26,353,890	17,569,260	8,784,631	(0)
Due to DHCS	35,038,446	30,744,662	28,225,971	24,429,978
Liability for In Home Support Services (IHSS)	413,549,552	413,549,552	413,549,552	413,549,551
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	83,657,353	86,276,451	95,703,417	92,470,504
Total Current Liabilities	**594,892,767**	**595,883,575**	**577,878,294**	**573,498,425**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	2,274,796	2,199,796	2,124,796	1,824,796
Total Non-Current Liabilities	**8,194,296**	**8,119,296**	**8,044,296**	**7,744,296**
Total Liabilities	**603,087,063**	**604,002,871**	**585,922,590**	**581,242,721**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**4,034,640**	**4,034,640**
Net Assets / Reserves				
Invested in Capital Assets	27,368,090	27,220,578	27,411,855	24,269,369
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	150,342,423	150,489,935	150,298,658	133,805,841
Current YTD Income (Loss)	8,056,809	148,514	248,141	19,635,303
Total Net Assets / Reserves	186,072,672	178,164,377	178,264,003	178,015,863
Total Liabilities, Deferred Inflows, and Net Assets	**793,194,374**	**786,201,888**	**768,221,233**	**763,293,224**

Cash Flow – YTD

Cash Flows from Operating Activities	
Premiums Received	511,707,272
Medical Expenses Paid	(486,532,113)
Adminstrative Expenses Paid	(38,240,247)
Net Cash from Operating Activities	**($13,065,088)**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(4,975,269)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	1,910,230
Net Increase/(Decrease) in Cash & Cash Equivalents	**(16,130,127)**
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Dec 18)	**$208,026,081**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**$8,056,809**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	1,876,548
Changes in Operating Assets/Liabilities	
Premiums Receivable	(41,333,799)
Other Receivable	(1,910,230)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(1,598,758)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	(10,433,330)
State Payable	36,962,358
Santa Clara Valley Health Plan & Kaiser Payable	3,678,463
Net Pension Liability	450,000
Medical Cost Reserves & PDR	(8,813,151)
IHSS Payable	0
Deferred Inflow of Resources	-
Total Adjustments	**($22,998,445)**
Net Cash from Operating Activities	**($13,065,088)**

Statement of Operations - YTD

Santa Clara Family Health Plan.

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Six Months Ending December 31 2018

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 440,903,715	$ 14,291,156	$ 58,792,037	$ 73,083,193	$ 2,091,805	**$ 516,078,713**
MEDICAL EXPENSE	$ 407,187,444	$ 14,876,651	$ 57,333,347	$ 72,209,998	$ 1,999,984	**$ 481,397,426**
(MLR)	92.4%	104.1%	97.5%	98.8%	95.6%	**93.3%**
GROSS MARGIN	$ 33,716,271	$ (585,495)	$ 1,458,690	$ 873,195	$ 91,821	**$ 34,681,287**
ADMINISTRATIVE EXPENSE	$ 23,687,296	$ 767,784	$ 3,158,568	$ 3,926,352	$ 112,381	**$ 27,726,030**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 10,028,974	$ (1,353,279)	$ (1,699,878)	$ (3,053,157)	$ (20,560)	**$ 6,955,257**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 941,093	$ 30,504	$ 125,490	$ 155,993	$ 4,465	**$ 1,101,552**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 10,970,068	$ (1,322,775)	$ (1,574,388)	$ (2,897,163)	$ (16,095)	**$ 8,056,809**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 299.90	$ 335.29	$ 1,289.75	$ 1,603.26	$ 106.45	**$ 336.12**
MEDICAL EXPENSES	$ 276.96	$ 349.03	$ 1,257.75	$ 1,584.11	$ 101.78	**$ 313.53**
GROSS MARGIN	$ 22.93	$ (13.74)	$ 32.00	$ 19.16	$ 4.67	**$ 22.59**
ADMINISTRATIVE EXPENSES	$ 16.11	$ 18.01	$ 69.29	$ 86.13	$ 5.72	**$ 18.06**
OPERATING INCOME/(LOSS)	$ 6.82	$ (31.75)	$ (37.29)	$ (66.98)	$ (1.05)	**$ 4.53**
OTHER INCOME/(EXPENSE)	$ 0.64	$ 0.72	$ 2.75	$ 3.42	$ 0.23	**$ 0.72**
NET INCOME/(LOSS)	$ 7.46	$ (31.03)	$ (34.54)	$ (63.56)	$ (0.82)	**$ 5.25**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	1,470,180	42,623	45,584	45,584	19,650	1,535,414
REVENUE BY LOB	85.4%	2.8%	11.4%	14.2%	0.4%	100.0%

Network Detection and Prevention Report

February 2019

Executive/Finance Committee Meeting

3/22/2019

Firewall Background

The following network intrusion reports show the malicious activities that were prevented from accessing SCFHP's network. It is important to note that these attempts are not specifically targeted at SCFHP, but rather are common attempts against entire areas of the Internet. The results are typical of many organizations.

None of the intrusion attempts on the SCFHP network were successful.

The attempts have been categorized in three severity levels:

High/Critical

These attacks are the most dangerous. They can take down our entire network or disable servers. Can take the form of various Backdoor, DDoS (Distributed Denial of Service), and DOS (Denial of Service) attacks.

Medium

These attacks can cause disruption to the network, such as increased network traffic that slows performance. For example, various DNS (Domain Naming Service), FTP (File Transfer Protocol), and Telnet attacks.

Low/Informational

These attacks are characterized more as informational events, such as various scans (port and IP internet protocol address), RPC (Remote Procedure Call), and SMTP (Simple Mail Transfer Protocol) attacks. The new informational category is from the recently implemented Palo Alto Firewall. These events are of low to no threat and are more of an FYI for reporting.

3/22/2019

Santa Clara Family Health Plan.

Attack Statistics Combined

October/November/December/January

	Number of Different Types of Attacks				Total Number of Attempts				Percent of Attempts			
Severity Level	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan	Oct	Nov	Dec	Jan
Critical	2	1	11	4	2	4	484	25	.001	.001	.59	.05
High	2	3	12	6	43	40	5200	2584	.003	.02	6.32	4.89
Medium	19	8	30	18	226	85	8547	442	.014	.04	10.39	.84
Low	28	33	35	7	162111	198902	35632	4237	99.47	99.86	43.33	8.01
Informational	2	4	22	17	599	158	32377	45605	.037	.08	39.37	86.22

Numbers are higher for December due to the change in firewalls from SonicWall to PAN-Firewall at our datacenter.

3/22/2019

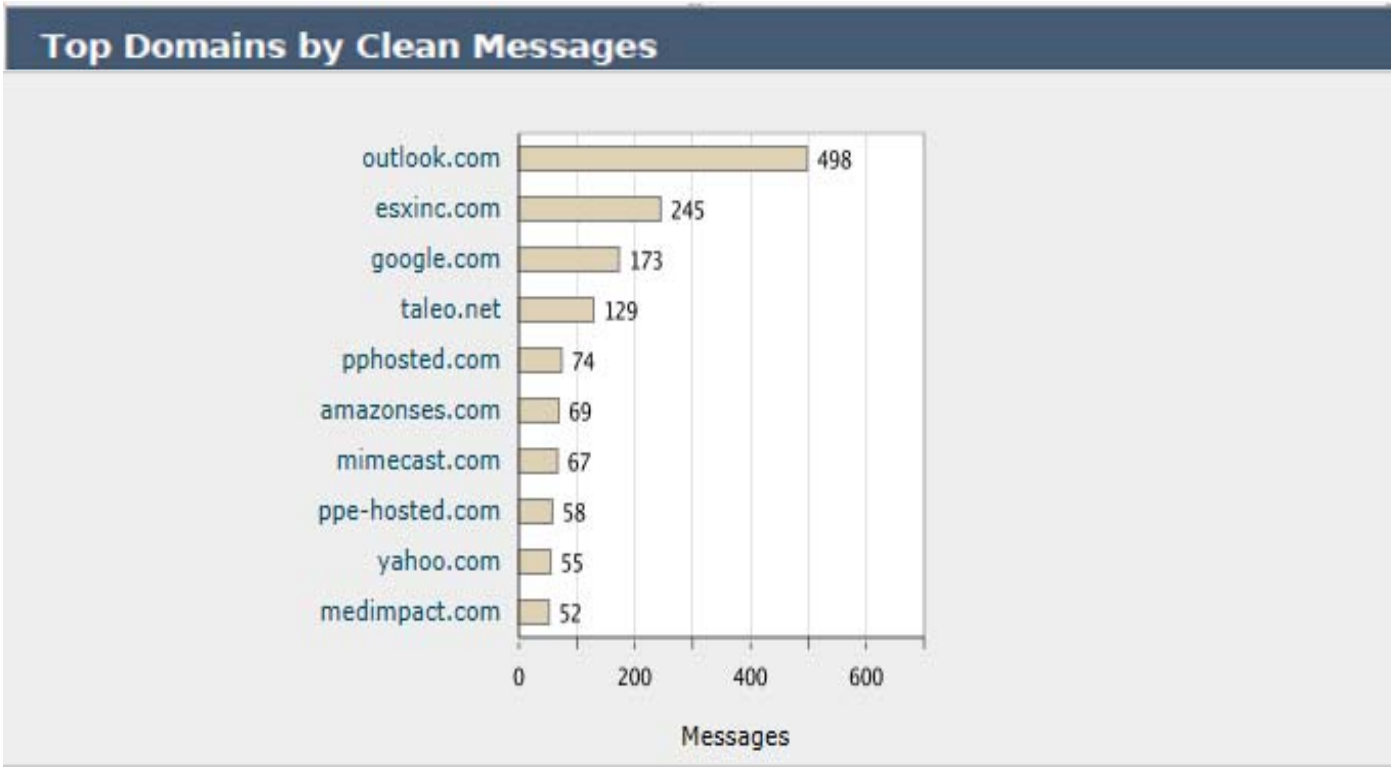
Email Background

For email protection, SCFHP utilizes software that intercepts every incoming email and scans for suspicious content, attachments, or URLs (Uniform Resource Locator or address to the World Wide Web). The software has anti-malware and phishing-detection technology that is constantly being updated to detect the latest threats. It is configured to detect phishing attempts as well as SPF (Sender Policy Framework) anti-spoofing. SPF is a simple technology that detects spoofing by providing a mechanism to validate the incoming mail against the sender's domain name. The software can check those records to make sure mail is coming from legitimate email addresses.

Email Security – Monthly Statistics

Incoming Mail Summary		
Message Category	%	Messages
Stopped by Reputation Filtering	57.4%	114.9k
Stopped as Invalid Recipients	0.0%	7
Spam Detected	6.0%	11.9k
Virus Detected	0.0%	3
Detected by Advanced Malware Protection	0.0%	0
Messages with Malicious URLs	0.2%	409
Stopped by Content Filter	0.1%	171
Stopped by DMARC	0.0%	0
S/MIME Verification/Decryption Failed	0.0%	0
Total Threat Messages:	**63.5%**	**127.0k**
Marketing Messages	8.8%	17.6k
Social Networking Messages	0.5%	904
Bulk Messages	5.0%	10.1k
Total Graymails:	**14.3%**	**28.6k**
S/MIME Verification/Decryption Successful	0.0%	0
Clean Messages	22.2%	44.5k
Total Attempted Messages:		**200.1k**

Email Security – Daily Statistics



Snapshot of one day – February 6th

Email Security – Country Blocking

UNITED ARAB EMIRATES	GERMANY	KUWAIT	RUSSIAN FEDERATION
AFGHANISTAN	FRANCE	KAZAKHSTAN	RWANDA
ALBANIA	UNITED KINGDOM	LIBERIA	SAUDI ARABIA
ANGOLA	GEORGIA	LIBYAN ARAB JAMAHIRIYA	SUDAN
BANGLADESH	HONG KONG	MYANMAR	SLOVENIA
BULGARIA	HONDURAS	MOZAMBIQUE	SLOVAKIA
BAHRAIN	CROATIA	NAMIBIA	SENEGAL
BERMUDA	INDIA	NIGERIA	SOMALIA
BOTSWANA	IRAQ	NETHERLANDS	SYRIAN ARAB REPUBLIC
CANADA	IRAN, ISLAMIC REPUBLIC OF	NAURU	TAJIKISTAN
CONGO, THE DEMOCRATIC REPUBLIC OF THE	JAPAN	PERU	UGANDA
CENTRAL AFRICAN REPUBLIC	KENYA	PHILIPPINES	UZBEKISTAN
CONGO	KYRGYZSTAN	PAKISTAN	VIET NAM
CHINA	CAMBODIA	QATAR	YEMEN
CUBA	KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF	ROMANIA	SOUTH AFRICA
CZECH REPUBLIC	KOREA, REPUBLIC OF	SERBIA	ZAMBIA
			ZIMBABWE

65 of 249 countries are being blocked

3/22/2019

SCFHP Phishing Attacks

Santa Clara Family Health Plan.

	INCIDENT 50 – 9/24/2018	INCIDENT 51 – 10/5/2018	INCIDENT 52 – 10/8/2018	INCIDENT 53 – 10/29/2018
TYPE OF ATTACK	Phishing	Phishing	Phishing	Phishing
SUMMARY	1 employee	1 employee	1 employee	1 employee
RESPONSE	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.
	Step 2. Block source email on Cisco Ironport - accounts@willerbymanor.co.uk and filtered expression "Remittance Advice". Blocked IP Address - 80.255.3.95	**Step 2.** Block source email on Cisco Ironport - ceo_dropbox@rieveergroup.com and filtered expression "Are you on Seat?" No IP available from email to block.	**Step 2.** Block source email on Cisco Ironport - noreply@microsoft-activation.jfkbjkl.website and filtered expression "Office365 Postmaster". No IP available from email to block.	**Step 2.** Block source email on Cisco Ironport - jimmyfall316@gmail.com and filtered expression "Quote of the day". Blocked IP address 209.185.167.195
	Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.
	Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.

SCFHP Phishing Attacks

Santa Clara Family Health Plan.

	INCIDENT 54 – 10/29/2018	INCIDENT 55 – 11/28/2018	INCIDENT 56 – 12/4/2018	
TYPE OF ATTACK	Phishing	Phishing	Phishing	
SUMMARY	1 employee	1 employee	1 employee	No incidents for month of January
RESPONSE	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	**Step 1.** Analyze email and take appropriate action.	
	Step 2. Block source email on Cisco Ironport - Jimmyteh@Conduent.com and filtered expression "Shipping Status changed" Blocked IP address 185.94.191.124	**Step 2.** Block source email domain on Cisco Ironport - @alertsp.chase.com and filtered expression "Account Notification #17769" Blocked IP address 173.203.187.96	**Step 2.** Block source email on Cisco Ironport – Support@sharefile.com and filtered expression "Citrix Sharefile Password Reset. Blocked IP address 34.192.163.240.	
	Step 3. Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	**Step 3.** Remove threat by permanently deleting email.	
	Step 4. Monitor email and user.	**Step 4.** Monitor email and user.	**Step 4.** Monitor email and user.	

Vendor Penetration Testing Objective

The Penetration (Pen) test for Santa Clara Family Health Plan (SCFHP) was conducted between December 17th and December 18th 2018 to help ensure that SCFHP's network is secure from advanced threat actors.

Additional objectives for this penetration test were based on industry standard guidelines as follows:

- Identification of vulnerabilities so that they can be identified and remediated prior to being exploited by an attacker
- Direct observation of physical access throughout the building to restricted areas or services
- Compromise of the domain by privileged users
- Sensitive data leakage or exfiltration
- Verification of network segmentation

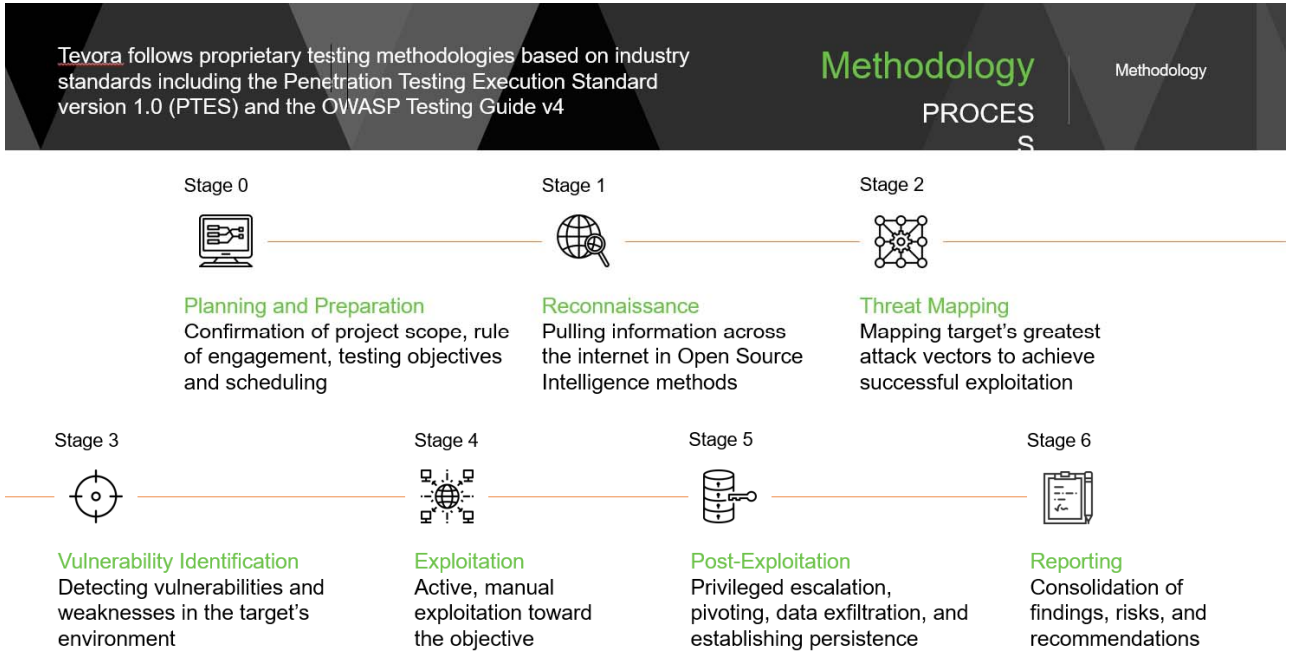
Vendor Overview

Tevora

– Founded in 2003, focused on CyberSecurity, Penetration Testing, Risk and Compliance Services.

– Used By other Leading Health Plans

– Solid methodology and approach towards risk mitigation



Approach & Scope

Santa Clara Family Health Plan has a policy of performing Penetration testing annually to ensure that any changes to the environment are tested and any new vulnerabilities are found and remediated.

The scope of the penetration test included the following:

- External Penetration Test – Performed network discovery and testing against SCFHP's internet-facing (external) assets in an attempt to identify exploitable weaknesses by a user who did not have physical access to SCFHP's office and/or internal network.

- Internal Penetration Test – Performed network discovery and testing against SCFHP's internal network environment in an attempt to identify exploitable weaknesses to gain unauthorized access to systems and data.

Why do Pen Testing?

Santa Clara Family Health Plan.

1. Cyber attacks and data breaches are becoming more prevalent. Across the board in all attack vectors, cyber attacks are continually increasing.

2. Data breaches carry tangible risk. Risks include damaged reputation and brand. Financial risks include fines from the FTC and other regulatory bodies. Data breaches in 2016 cost an estimated $3.8 million which was a 23% increase from prior years.

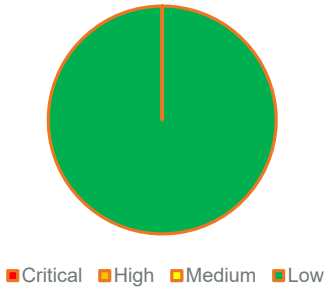
3. Executive management has a fiduciary duty to protect customer information. Failure in this duty could lead to personal liability.

Results - Summary

External Penetration Test – **No** Critical, High or Medium vulnerabilities were found! Tevora was not able to penetrate SCFHP's external defenses.

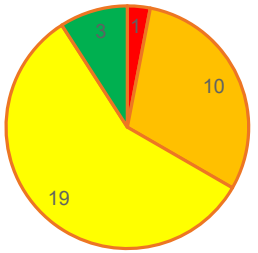
Internal Penetration Test – Tevora discovered 33 vulnerabilities (Critical (1), High (10), Medium (19), Low (3) within the SCFHP environment. IT Management has already taken actions to remediate the Critical and High priority vulnerabilities, and is currently working to remediate the Medium priority vulnerabilities.

External Results



1 Finding

Internal Results



33 Findings

Results - Detail

The internal results centered around the below areas ---

Area	Critical	High	Medium	Low
Patch Management	1	4	6	
Password Management, Credentials		1	7	0
Access/Permissions/Authentication			2	4
Unsupported Operating Systems, Applications, Hardware		5	4	
Total	**1**	**10**	**19**	**4**

Questions

3/22/2019

Regular Meeting of the
Santa Clara County Health Authority
Compliance Committee

Thursday, February 28, 2019
1:00 PM – 2:30 PM
6201 San Ignacio Ave.
San Jose, CA 95119

Minutes - DRAFT

Members Present

Linda Williams, Board Member
Christine M. Tomcala, Chief Executive Officer
Robin Larmer, Chief Compliance and Regulatory Affairs Officer
Chris Turner, Chief Operations Officer
Laurie Nakahira, DO, Chief Medical Officer

Staff Present

Beth Paige, Interim Director, Compliance
Mai Phuong Nguyen, Compliance Oversight Mgr.
Ron Smothers, Medicare Compliance Program Manager
Regina Wong-Valle, Compliance Audit Manager

1. **Roll Call**

   Ms. Larmer called the meeting to order at 1:25 pm. Roll call was taken and a quorum established.

2. **Public Comment**

   There were no public comments.

3. **Approve Minutes of the November 15, 2018 Regular Compliance Committee Meeting**

   Minutes of the November 15, 2018 regular Compliance Committee meeting were approved with a correction on page 2, under 5(c), clarifying that one pre-delegation audit will be done for potential new delegates (there is no separate pre-delegation audit for NCQA purposes).

4. **CMS Program Audit**

   Ms. Larmer reminded the Committee that CMS identified 25 Corrective Action Required Conditions (CARs) and 6 Immediate Corrective Action Required Conditions (ICARs) in its Final

report on the 2018 Program Audit. CMS notified the Plan on February 1, 2019 that the proposed Corrective Action Plans (CAPs) had been accepted. Work on the CAPs is in process and being tracked on a master CAP task tracker. There is a great deal of work to be done, but at present, Ms. Larmer has not identified any material barriers to completion of the required remediation.

The Plan is in the process of engaging an independent audit firm to conduct an Independent Validation Audit (IVA), as required by CMS. The IVA report and the CEO's attestation that all Conditions have been corrected must be submitted to CMS by July 31, 2019, unless an extension is granted.

Ms. Larmer reported that CMS was levying a $39,000 civil monetary penalty on the plan based on the two audit conditions that had the largest member impact (related to timeliness of standard and expedited authorizations).

5. Compliance Activity and Audit Report

a) Ms. Paige presented the status of State Regulatory Audits.
The Plan continues to prepare for the Joint DMHC/DHCS audit. There is a larger emphasis on delegation oversight with regulators requesting delegate files for review as well. DHCS plans to visit VHP the second week of audit. There have been more extensive records requests than in past years with regulators already beginning record reviews and submitting questions for response, prior to being onsite.

b) Delegation Audits and Corrective Action Plans:
It was noted that the plan continues to work with 5 delegates to close open corrective action plans post 2018 annual and/or focus audits. Two CAPs were closed between November and December 2018.

c) Ms. Larmer reported that SCFHP received a 3-year accreditation from NCQA.

A **motion** was made to accept the Compliance Activity and Audit Report; the motion was **seconded and unanimously approved.**

6. Compliance Program Enhancements

Ms. Larmer and Ms. Nguyen reported that the Compliance Department had developed a Compliance Guide for First Tier, Downstream and Related Entities. It is posted on the SCFHP website and explains SCFHPs Compliance Program, defines a FDR and contains an annual Compliance Attestation whereby delegates attest to adherence to the requirements of SCFHP. The Guide and Attestation were reviewed with the Committee.

7. Review CMC and Medi-Cal Compliance Dashboard and Work Plans

Ms. Nguyen presented the Compliance Dashboard for Q4 2018. She highlighted performance for each of the functional areas and those areas that submitted a CAP/Work Plan.

The functional areas that did not meet their goals, and from which CAPs were requested, included:

- Enrollment
- Customer Service
- Case Management
- Grievance and Appeals

Chris Turner, COO, noted that for Customer Service, the biggest issue has been staffing. They are improving key metrics, evaluating salary ranges, and other activities to attract and retain staff. There have also been phone issues that have caused the business unit to not improve its dashboard numbers. She also commented that Grievance and Appeals was improving, noting that only 2 out of 15 CMC elements were non-compliant in January. This substantial improvement is attributed largely to increased staffing, including a new supervisor and representatives.

The Plan is re-evaluating its dashboard metrics to ensure the Plan is focused on measuring regulatory/contractual requirements.

A **motion** was made to approve the Compliance Dashboard; the motion was **seconded and unanimously approved.**

8. **Review Compliance Policies**

Ms. Larmer presented 7 Compliance policies for Committee review. She explained the policies reflect several of the measures put in place following the CMS Program Audit. Because the final policy and procedure templates are not finalized, Ms. Larmer sought approval of the substance of the policies only. The following policies were reviewed:

- Exclusion Screening – CP.09
- Compliance Training – CP.10
- Standards of Conduct – CP.15
- Annual CPE Audit – CP.12
- Risk Assessment – CP17
- FDR Contracting – CP.16
- Corrective Action – CP.07

A **motion** was made to approve in substance the above policies, with recommended changes to CP.09 (omitted word/spelling) and CP.16 (remove approval limitation amounts and incorporate will follow FIN.03 Cash Disbursement policy); the motion was **seconded and unanimously approved.**

9. **Fraud, Waste and Abuse Report**

a) Discuss any credible FWA cases and recovery efforts

Ms. Larmer reported that the FWA Vendor, T&M Protection Resources, continues to do data mining and has sent several letters out to providers requesting additional information. The Committee will be kept apprised of any actions taken.

A **motion** was made to approve the Fraud, Waste and Abuse Report; the motion was **seconded and unanimously approved**.

10. Adjournment

The meeting was adjourned at 2:20 pm.

Compliance Activity Report
February 28, 2019

2018 CMS Program Audit Update

The Plan received CMS' Final Report on December 13, 2018. The Report cited a total of 25 Corrective Action Required (CAR) Conditions, in addition to the 7 Immediate Corrective Action Required (ICAR) Conditions previously identified. The Plan submitted Corrective Action Plans (CAPs) for each of the CARs, and on February 1, 2019, all CAPs were deemed reasonable and accepted by CMS (ICARS were previously submitted to and accepted by CMS).

Pursuant to Audit protocol, the Plan must engage an independent audit firm to validate the Plan's correction of the Conditions cited in the Report. The independent auditor's report, and the CEO's attestation that all Conditions have been corrected, must be submitted to CMS within 180 days of CMS' acceptance of the CAPs, or by July 31, 2019. The Plan is in the process of engaging a validation audit firm, and work on all CAPs is ongoing (please refer to accompanying CAP tracker).

On February 27, 2019, the Plan was advised that a Civil Monetary Penalty will be imposed, as anticipated.

Cal MediConnect

- The 2018 Medicare Data Validation (MDV) corrective actions have been completed. The Plan is in preparation for the 2019 MDV audit (to be scheduled).
- The Plan completed its 2018 HSAG/PMV Audit. Out of the three measures reviewed, the audit team was able to validate the data for Core Measure 2.1 (members with an assessment within 90 days of enrollment). The audit team was unable to validate measures CA 1.2 (high risk members with ICP within 30 working days after HRA) and CA 1.4 (low risk members with an ICP within 30 working days of HRA) because Q1 – Q3 activity was conducted by a former vendor, and the Plan is unable to access the vendor's system to validate the corresponding data. HSAG raised no concerns regarding SCFHP's data for Q4 (when services were conducted in-house), but ultimately did not have sufficient data to justify a "reportable" designation.
- Annual CMC Reporting of Core and CA Specific measures is due at the end of February 2019. Compliance has been working with various Business Units on preparing the data for submission.
- Compliance has revised its process for dissemination of guidance received through HPMS memos to encourage greater engagement by business units and enhance Compliance's monitoring of implementation of the guidance.
- Internal audit tools are being updated to ensure the tools match CMS/DHCS 2019 CMC guidance and specifications.

CMS Notice of Noncompliance

The Plan received a CMS Notice of Noncompliance for failure to submit two attestations by the deadline in June 2018.

Medi-Cal

- SCFHP issued a 2019 EOC Errata to members to advise them of the new 2019 Medi-Cal benefits (Pediatric Palliative Care, Diabetes Prevention Program and the Health Home Program). A full EOC will be made available once DHCS issues the 2019 EOC template to Plans (anticipated in early spring 2019).
- DHCS is planning to move County Children's Health Initiative Program (CCHIP) into Medi-Cal in 2019. This shift will affect SCFHP, Santa Francisco Health Plan and Health Plan of San Mateo. The details of the transition are still being worked out.

2018 DHCS Audit

The Plan submitted additional information for the 8 CAPs that were requested for the 2018 DHCS Follow-Up Audit. The additional information was reviewed, and DHCS has accepted the CAPs and closed the audit.

2019 DMHC and DHCS Audit(s)

As previously reported, DMHC will conduct a Routine survey of the Plan starting on March 18, 2019. DHCS will also conduct its 2019 audit concurrently in March 2019, with some (but not all) activities conducted jointly with DMHC.

Both agencies have requested and been provided pre-audit documentation and data universes, and we continue to receive follow up requests. In general, the volume of pre-audit material and depth of the auditors' inquiries, particularly with respect to delegation oversight, appears more detailed than in previous years.

DMHC Complaints

The Plan received a total of 19 member complaints between November 2018 and January 2019. Two cases were forwarded to IMR.

Operational Compliance Report (Dashboard) – Corrective Actions

- Enrollment missed two measures in January 2019 due to late file submission by the vendor.
  - Two CMC CAPs were issued to the Business Unit on February 20, with a response expected by February 27, 2019.
- Customer Service's measures have shown a positive trend upward, but they remain below goal.
  - Two CMC CAPs and four Medi-Cal CAPs were issued to the Business Unit on February 20, 2019, with an expected response by February 27, 2019.
- Case Management continues an upward trend for CMC HRA and ICP completion. For Medi-Cal, the data provided for two SPD HRAs measures does not meet the goal, and data for two measures is missing.
  - Two CMC CAPs and four Medi-Cal CAPs were issued to the Business Unit on February 20, 2019, with an expected response by February 27, 2019.
- Grievance and Appeals metrics have fluctuated for both CMC and Medi-Cal, with a negative trend downward for many elements.
  - The Business Unit will be asked to update its work plan for achieving compliance in 2019.

Joint Operations Committee (JOC) Meetings

The following JOCs have been held since the last Compliance Committee Meeting:

- December: Kaiser, County Behavioral Health Services Department, VSP
- January: Liberty Dental, Signify Health (Advance Health), Focus Care
- February: DocuStream, VHP, CHME, CBHSD, Language Line, PMG, Cotiviti (Verscend), Carenet, MedImpact

HIPAA Disclosures

There were 6 unauthorized disclosures of PHI between November 2018 and January 2019. All were reported to DHCS, though none were determined to constitute a breach. The Compliance team is currently evaluating the need for refreshed and/or enhanced HIPAA training for staff and FDRs.

FWA Activities

No new cases of potential FWA have been identified since November 2018. However, T&M has requested and is awaiting medical records from 6 providers in connection with anomalies identified through its datamining activities.

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2018

Cal MediConnect CY 2018	Goal	Q2 2018	Q3 2018	Q4 2018
ENROLLMENT				
Enrollment Materials				
% of New member packets mailed within 10 days of effective Date	100%	Met	Not Met	Met
% of New Member ID cards mailed within 10 days of effective date	100%	Met	Not Met	Met
Out of Area Members				
% Compliance with OOA Member Process	100%	Met	Met	Met
CUSTOMER SERVICE				
Combined Call Stats				
Member				
Member Average Speed of Answer in Seconds	≤30 Seconds	Not Met	Not Met	Not Met
Member Average Hold Time in Seconds	≤120 Seconds	Met	Met	Met
Member Abandonment Rate	≤5%	Not Met	Met	Met
Member Service Level	80% in ≤30 Seconds	Met	Not Met	Not Met
UTILIZATION MANAGEMENT				
Pre-Service Organization Determinations				
Standard Part C				
% of Timely Decisions made within 14 days	100%	Not Met	Met	Met
Expedited Part C				
% of Timely Decisions made within 72 Hours	100%	Not Met	Met	Met
Post Service Organization Determinations				
% of Timely Decisions made within 30 days	100%	Met	Not Met	Met
CASE MANAGEMENT				
HRAs and ICPs				
% of HRAs completed in 45 days for High Risk Members	100%	Not Met	Not Met	Not Met
% of HRAs completed in 90 days for Low Risk Members	100%	Not Met	Met	Met
% of ICPs completed within 30 days for High Risk Members	100%	Not Met	Not Met	Met
% of ICPs completed within 30 working days for Low Risk Members	100%	Not Met	Not Met	Not Met

Medi-Cal CY 2018	Goal	Q2 2018	Q3 2018	Q4 2018
ENROLLMENT				
Enrollment Materials				
% of New member packets mailed within 7 days of effective Date	100%	Met	Met	Met
% of New Member ID cards mailed within 7 days of effective date	100%	Met	Met	Met
CUSTOMER SERVICE				
Call Stats				
Member Queue				
Member Average Speed of Answer in Seconds	≤30 Seconds	Not Met	Not Met	Not Met
Member Average Hold Time in Seconds	≤120 Seconds	Met	Met	Met
Member Abandonment Rate	≤5%	Not Met	Not Met	Not Met
Member Service Level	80% in ≤30 Seconds	Not Met	Not Met	Not Met
HEALTH SERVICES				
Medical Authorizations				
Routine Authorizations				
% of Timely Decisions made within 5 Business Days of request	95%	Not Met	Met	Met
Expedited Authorizations				
% of Timely Decisions made within 72 Hours of request	95%	Not Met	Met	Met
Retrospective Review				
% of Retrospective Reviews completed within 30 Calendar Days of request	95%	Met	Met	Met
QUALITY & CASE MANAGEMENT				
Initial Health Assessment				
% of High Risk SPD Members who completed HRA in 45 days	100%	Report Pending	Report Pending	Not Met
% of HRAs completed in 90 days for Low Risk SPD Members	100%	Report Pending	Report Pending	Not Met
% of HRAs completed in 45 days for High Risk MLTSS Members	100%	Report Pending	Report Pending	Report Pending
% of HRAs completed in 90 days for Low Risk MLTSS Members	100%	Report Pending	Report Pending	Report Pending
Facility Site Reviews				
% of FSRs completed timely	100%	Met	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2018

Cal MediConnect CY 2018	Goal	Q2 2018	Q3 2018	Q4 2018
CLAIMS				
Non-Contracted Providers				
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Not Met	Not Met	Met
Contracted Providers				
% of Claims to Contracted Providers processed within 45 days	90%	Met	Met	Met
% of Claims to Contracted Providers processed within 90 days	99%	Met	Met	Met
% of Claims to Contracted Providers processed beyond 90 days	≤1%	Met	Met	Met
PHARMACY - PART D				
Standard Part D Authorization Requests				
% of Standard Prior Authorizations completed within 72 Hours	100%	Met	Met	Met
Expedited Part D Authorization Requests				
% of Expedited Prior Authorizations completed within 24 Hours	100%	Met	Met	Met
Other Pharmacy Requirements				
Formulary posted on website by 1st of the month	100%	Met	Met	Met
Step Therapy posted on website by 1st of the month	100%	Met	Met	Met
PA criteria posted on website by 1st of the month	100%	Met	Met	Met
% MTM/CMR Completion Rate	22%	Annual Measure	Annual Measure	Met
GRIEVANCE & APPEALS				
Grievances, Part C				
Standard Grievances Part C				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Not Met	Not Met	Not Met
% of Standard Grievances resolved within 30/44 days	100%	Met	Not Met	Not Met
Expedited Grievances Part C				
% of Expedited Grievances resolved within 24 hours	100%	Met	Met	Met
Grievances, Part D				
Standard Grievance Part D				
% of Standard Grievances that received Acknowledgement Letters within 5 days and were not resolved in < 5 calendar days	100%	Met	Met	Met
% of Standard Grievances resolved within 30/44 days	100%	Met	Met	Met

Medi-Cal CY 2018	Goal	Q2 2018	Q3 2018	Q4 2018
CLAIMS				
Non-Contracted Providers				
% of Clean Claims to Non-Contracted Providers processed within 30 days	90%	Met	Met	Met
Contracted Providers				
% of Claims to Contracted Providers processed within 45 working days	90%	Met	Met	Met
Provider Claim Dispute Requests (Contracted & Non-Contracted)				
% of Contracted Provider Disputes Processed within 45 days	100%	Met	Not Met	Met
PHARMACY				
Standard Authorization Request				
% of Standard Prior Authorizations completed within 24-hours July 1 2017	95%	Met	Met	Met
Expedited Authorization Request				
% of Standard Prior Authorizations completed within 24-hours July 1 2017	95%	Met	Met	Met
GRIEVANCE & APPEALS				
Grievances				
Standard Grievances				
% of Grievances resolved within 30 days	100%	Met	Not Met	Not Met
Expedited Grievances				
% of Expedited Grievances resolved within 72 hours	100%	Not Met	Not Met	Not Met
% of Expedited Grievances that received Oral Notification within 72 hours	100%	Not Met	Not Met	Not Met
% of Expedited Grievances that received Resolution Letters within 72 hours	100%	Not Met	Not Met	Not Met
Appeals				
Standard Appeals				
% of Acknowledgement Letters sent within 5 calendar days	100%	Not Met	Not Met	Not Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan™

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2018

Cal MediConnect CY 2018	Goal	Q2 2018	Q3 2018	Q4 2018
Expedited Grievance Part D				
% of Expedited Grievances resolved within 24 hours	100%	Met	Met	Met
Reconsiderations, Part C				
Standard Post-Service Part C				
% of Standard Post-Service Reconsiderations resolved within 60 days	100%	Not Met	Met	Not Met
Standard Pre-Service Part C				
% of Standard Pre-Service Reconsiderations that received Acknowledgement Letters within 5 days	100%	Not Met	Not Met	Not Met
% of Standard Pre-Service Reconsiderations resolved within 30/44 days	100%	Met	Met	Not Met
Expedited Pre-Service Part C				
% of Expedited Pre-Service Reconsiderations resolved with oral notification to member within 72 Hours	100%	Not Met	Not Met	Met
% of Expedited Pre-Service Reconsiderations resolved with written notification to member within 72 Hours	100%	Not Met	Met	Met
% Expedited Pre-Service Reconsiderations (upheld & untimely) submitted to IRE within 24-hours of decision	100%	Met	Met	Met
Redeterminations, Part D				
Standard Part D				
% of Standard Redeterminations resolved within 7 calendar days	100%	Not Met	Not Met	Met
Expedited Part D				
% of Expedited Redeterminations resolved with oral notification to member within 72 Hours	100%	Not Met	Not Met	Met
% of Expedited Redeterminations resolved with written notification to member within 72 hours	100%	Not Met	Met	Met
% of Untimely Expedited Redeterminations Submitted to IRE within 24 Hours of decision	100%	Met	Met	Not Met
COMPLAINT TRACKING MODULE (CTM) COMPLAINTS				
% Resolved Timely	100%	Met	Not Met	Not Met
PROVIDER RELATIONS				
Provider Directories updated monthly by the first day of the month	100%	Met	Met	Met
Monthly Excluded Provider Screening Completed (Independent Providers)	100%	Met	Met	Met
MARKETING				
% of Marketing Materials Submitted for Approval	100%	Met	Met	Met
% of Events Submitted for Approval	100%			
FINANCE				
Monthly submission of encounters	100%	Met	Met	Met
% of Encounters submitted to CMS within 180 days of date of Service	80%	Met	Met	Met
% of RAPS records successfully submitted to CMS (not duplicate)	95%	Met	Met	Met

Medi-Cal CY 2018	Goal	Q2 2018	Q3 2018	Q4 2018
% of Standard Appeals resolved within 30/44 calendar days	100%	Not Met	Not Met	Met
Expedited Appeals				
% of Expedited Appeals Resolved within 72 hours	100%	Not Met	Not Met	Not Met
% of Expedited Appeals that received Oral Notification within 72 hours	100%	Not Met	Not Met	Not Met
% of Expedited Appeals that received Resolution Letters within 72 hours	100%	Not Met	Not Met	Not Met
PROVIDER NETWORK MANAGEMENT				
% of New Independent Providers Rec'd Orientation within 10 days	100%	Met	Met	Met
Monthly Excluded Provider Screening Completed	100%	Met	Met	Met
Timely Access Surveys (due in June)	100%	Met	Met	Met
INFORMATION TECHNOLOGY				
% Encounter Files Successfully Submitted to DHCS by end of month	100%	Met	Met	Met
% Monthly Eligibility Files successfully submitted to Delegates Timely	100%	Met	Met	Met
% Provider File submitted to DHCS by last Friday of Month	100%	Met	Met	Met

Met = Measure substantially but not fully met; CAP/adverse action unlikely (or not anticipated)

Santa Clara Family Health Plan

Santa Clara Family Health Plan – Operational Compliance Report – Calendar Year 2018

Company Wide Compliance CY 2018				
	Goal	Q2 2018	Q3 2018	Q4 2018
COMPLIANCE TRAINING				
% New Employee Training Completed Timely	100% completed within 3 business days	Not Met	Not Met	Met
% Annual Employee Training Completed	100% completed by year end	Annual Measure	Annual Measure	Met
BOARD OF DIRECTORS TRAINING				
% Annual Board Training Completed Timely	100% completed by year end	Annual Measure	Annual Measure	Annual Measure
HUMAN RESOURCE				
Excluded Individual Screening Completed Monthly	100%	Met	Met	Met
INTERNAL AUDITS				
% of Internal Audits Completed	100% completed by year end	Met	Met	Met
DELEGATION OVERSIGHT				
% of Scheduled Audits Completed	100%	Met	Met	Met
REPORTING				
% of CMC Routine Reports Submitted Timely	100%	Met	Met	Met
% of Medi-Cal Routine Reports Submitted Timely	100%	Met	Met	Met
FILINGS				
% of Key Personnel Filings Timely	100%	Met	Not Met	Met

POLICY

Policy Title:	**Exclusion Screening**	**Policy No.:**	CP.09 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to monitor Santa Clara Family Health Plan's (SCFHP) new employees, temporary employees, existing employees, volunteers, interns, consultants, FDRs and governing body members to ensure they are permitted to work government-funded health care programs.

II. Policy

SCFHP implements an ongoing process to review the Office of Inspector General (OIG) and General Services Administration (GSA) exclusion lists.

III. Responsibilities

1. SCFHP reviews OIG and GSA exclusion lists prior to hiring, contracting or the appointment of an individual to the governing body to ensure the prospective individual or entity has not been excluded from working in government-funded health care programs. This review also applies to volunteers and interns.
2. SCFHP reviews OIG and GSA exclusion lists on a monthly basis to ensure employees, temporary employees, volunteers, interns, consultants, FDRs and Governing Board members have not been excluded from working in government-funded health care programs.
3. Exclusion screening is a cross-departmental activity and managed by the following business units:
    a. Human Resources is responsible for conducting exclusion screening for all staff, including temporary staff, volunteers, interns and consultants, and the Governing Body.
    b. Provider Network Management, in collaboration with the Compliance Department, is responsible for exclusion screening contracted providers, FDRs and non-FDR vendors.
    c. Claims, in collaboration with the IT Department, is responsible for conducting exclusion screening for non-contracted providers prior to remittance for any approved claims.

IV. References

The Social Security Act §1862(e)(1)(B)

42 C.F.R. § 422.503(b)(4)(vi)(F)
42 C.F.R. § 422.752(a)(8), 423.504(b)(4)(vi)(F)
42 C.F.R. § 423.752(a)(6)
42 C.F.R. § 1001.1901
Medicare Managed Care Manual, Chapter 21, Section 50.6.8
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.6.8
CA Welfare and Institutions Code, §§ 14043.6 and 14123

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
Ron Smothers Medicare Compliance Manager Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date	Christine M. Tomcala Chief Executive Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Compliance Committee of the Board		

POLICY

Policy Title:	**Compliance Training**	**Policy No.:**	CP.10 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to ensure all Santa Clara Family Health Plan (SCFHP) employees, temporary staff, volunteers, consultants, and board members ("Employees") and first-tier, downstream and related entities (FDRs) receive appropriate training and comply with all state, federal and SCFHP compliance requirements and policies.

II. Policy

SCFHP ensures that all Employees and FDRs receive general compliance training that includes SCFHP's Standards of Conduct and compliance policies and procedures, and FWA training upon hire, appointment or contract, upon any updates in regulatory requirements, and annually thereafter (within the 12-month period from the prior training cycle).

III. Responsibilities

1. General compliance and FWA training is a cross-departmental activity and managed by the following business units:
   a. Human Resources, in collaboration with the Compliance Department, is responsible for conducting new hire orientation training that includes general compliance and FWA training within 90 days of hire for all Employees, upon updates to regulatory requirements, and annually thereafter.
   b. Provider Network Management is responsible for communicating the requirements for SCFHP's contracted provider network to provide new hire and annual general compliance training to its staff.
   c. The Compliance Department is responsible for communicating to SCFHP's FDRs the requirements for providing general compliance and FWA training to all FDR staff within 90 days of hire, upon updates to regulatory requirements, and annually thereafter.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(C)
42 C.F.R. § 423.504(b)(4)(vi)(C)
Medicare Managed Care Manual, Chapter 21, Section 50.3.1
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.3.1

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
Ron Smothers Medicare Compliance Manager Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date	Christine M. Tomcala Chief Executive Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Compliance Committee of the Board		

POLICY

Policy Title:	**Standards of Conduct**	**Policy No.:**	CP.15 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to state Santa Clara Family Health Plan (SCFHP)'s overarching principles and values by which SCFHP operates and define the underlying framework for its compliance policies and procedures.

II. Policy

SCFHP has formal Standards of Conduct describing the expectations that apply to all employees, temporary employees, volunteers, interns, consultants and Governing Body members (Employees) and first tier, downstream and related entities (FDRs) in conducting themselves in an ethical manner.

III. Responsibilities

1. SCFHP's Compliance Officer is responsible for:
   a. Updating the Standards of Conduct to incorporate changes in applicable laws, regulations, and other program requirements; and
   b. Obtaining approval from the Compliance Committee of the Board whenever updates are made to the Standards of Conduct.
2. SCFHP's Human Resources is responsible for ensuring that the Standards of Conduct and the underlying compliance policies and procedures are distributed to all Employees upon hire and annually thereafter.
3. SCFHP's Compliance Manager is responsible for ensuring all FDRs have access to SCFHP's Standards of Conduct.
4. The Compliance Committee of the Board is responsible for review and approval of updates made to the Standards of Conduct.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(A)
42 C.F.R. § 423.504(b)(4)(vi)(A)

POLICY

Medicare Managed Care Manual, Chapter 21, Section 50.1.1
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.1.1

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
Ron Smothers Medicare Compliance Manager Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date	Christine M. Tomcala Chief Executive Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Compliance Committee of the Board		

POLICY

Policy Title:	**Annual Compliance Program Effectiveness Audit**	**Policy No.:**	CP.12 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to establish the standards that Santa Clara Family Health Plan (SCFHP) utilizes to implement, monitor, measure and promote an effective compliance program that detects, corrects and prevents non-compliance and fraud, waste and abuse.

II. Policy

SCFHP performs an annual, comprehensive compliance program audit or assessment to measure the overall effectiveness of its compliance program.

III. Responsibilities

1. SCFHP's compliance department identifies qualified, independent individuals or entities that are subject matter experts in conducting annual compliance program audits or assessments.
2. The Compliance Committee will review and approve the Compliance Officer's candidates prior to the award of the contract.
3. SCFHP's Compliance Officer and Compliance Committee are responsible for reviewing the compliance program audit or assessment report and making recommendations for corrective actions, where appropriate.
4. The compliance department conducts regular monitoring of compliance program operational activities through the use of established dashboard metrics.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(F)
42 C.F.R. § 423.504(b)(4)(vi)(F)
Medicare Managed Care Manual, Chapter 21, Section 50.6.7
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.6.7

POLICY

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
Ron Smothers Medicare Compliance Manager Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date	Christine M. Tomcala Chief Executive Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Compliance Committee of the Board		

POLICY

Policy Title:	**Risk Assessments**	**Policy No.:**	CP.17 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to establish Santa Clara Family Health Plan (SCFHP)'s commitment to identifying, prioritizing, and assigning accountability for managing existing or potential threats related to noncompliance or ethical misconduct that could lead to fines or penalties, reputational damage, or the inability to continue operations in its government-funded health care programs.

II. Policy

SCFHP employs a standardized and consistent methodology for assessing its internal operational risks, contractual and regulatory risks, as well as the risks associated with delegated activities performed by it first tier, downstream and related entities (FDRs) that is designed to prioritize monitoring and auditing activities according to specified risk categorizations.

III. Responsibilities

1. SCFHP's Compliance Officer is responsible for the:
   a. Development and maintenance of SCFHP's risk assessment system;
   b. Annual implementation of the risk assessment process;
   c. Annual effectiveness reviews of the risk assessment system;
   d. Education of all stakeholders on the results and implications of the annual risk assessment; and
   e. Development of an annual monitoring and auditing work plan derived from the results of the annual risk assessment.
2. SCFHP's Compliance Managers are responsible for establishing monitoring and auditing schedules based on the risk prioritization established by the risk assessment process.
3. SCFHP's FDR Compliance Manager is responsible for educating FDRs on SCFHP's risk assessment policy and procedure.
4. The Compliance Committee of the Board is responsible for assisting with the implementation and oversight of the risk assessment process, including approval of the annual monitoring and auditing work plan that is derived from the annual risk assessment process.

5. The Governing Body is responsible for reviewing and approving the risk assessment process.

IV. References

42 C.F.R. §§ 422.503(b)(4)(vi)(B) and (F)
42 C.F.R. §§ 423.504(b)(4)(vi)(B) and (F)
Medicare Managed Care Manual, Chapter 21, §§ 50.2.2, 50.2.3, 50.6.2
Medicare Prescription Drug Benefit Manual, Chapter 9, §§ 50.2.2, 50.2.3, 50.6.2

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
Ron Smothers Medicare Compliance Manager Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date	Christine M. Tomcala Chief Executive Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Compliance Committee of the Board		

POLICY

Policy Title:	**First Tier, Downstream, Related Entity and Vendor Contracting**	**Policy No.:**	CP.16 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to ensure that Santa Clara Family Health Plan (SCFHP) follows a standardized protocol in the development, negotiation, and approval of all first tier, downstream, related entities (FDRs) and non-FDR vendors contracts and agreements for any purpose and for any amounts between SCFHP and other parties.

II. Policy

SCFHP complies with all statutory and regulatory requirements regarding the content of its FDR and non-FDR vendor contracts. SCFHP requires its FDRs and non-FDR vendors to comply with the same requirements with respect to any subcontracts executed in support of SCFHP's government programs and the members enrolled in those programs.

III. Responsibilities

1. Contract Initiation and Review. The individual initiating the contract on behalf of SCFHP and subsequent reviewers are responsible for reading the entire contract and determining that its content, objectives, definitions, and terms are compliance with state, federal and 3-way contract requirements.
    a. Business Owner. Business owners that initiate a new contract, agreement, letter of intent (LOI) or letter of agreement (LOA) must ensure that the contract contains the following before submitting the contract, LOI or LOA to the Contracting Department:
        i. Accurately reflect agreements made during negotiations; and
        ii. Is consistent with the business unit's regulatory or administrative requirements.
    b. Contracting Department. The Contracting Department ensures that the contract, LOI or LOA meets the following standards before submitting the contract, LOI or LOA to Compliance:
        i. Contains the standard terms and conditions required by SCFHP, to the extent applicable;
        ii. Contractual provisions are clear and consistent throughout; and
        iii. Use of the appropriate SCFHP contract template.
    c. Compliance. The Compliance Department is responsible for ensuring that the contract, LOI or LOA is:
        i. Free of any conflicts of interest for the parties affected by the contract;

ii. Compliant with SCFHP's regulatory contracts;
iii. Compliant with state and federal laws, as may be applicable;
iv. Routed to the appropriate executive team member for review prior to signing; and
v. Delivered to the Contracting Department for appropriate filing, tracking and storage.

2. Approvals. The authority to approve and sign contracts, LOIs or LOAs on behalf of SCFHP rests with the authorized executive team members identified in Exhibit A to this policy. In some cases, additional approval by the Board of Directors may be required.

3. Approval Limitations.
   a. All Contracts, LOIs, LOAs with a value under $250,000 must be approved by the Chief Executive Officer.
   b. All Contracts, LOIs, LOAs with a value over $250,000 must be approved by the Board of Directors.
   c. Other contracts, LOIs or LOAs that do not commit organization funds must be approved or signed by the individuals identified on Exhibit A. However, all contracts, LOIs or LOAs that meet any of the following criteria, must be reviewed and approved by the CEO and CFO:
      i. New projects that have not been already approved as part of the budget process;
      ii. Contracts/LOIs/LOAs over $50,000 but under $250,000;
      iii. New significant business relationships (e.g., FDRs, vendors, consulting firms, etc.);
      iv. Any contract/LOI/LOA or business relationship where either money or services are a part of SCFHP's contractual obligations to either CMS, DHCS or DMHC;
      v. Capital projects;
      vi. Projects that involve multiple departments or have an impact on several departments; and
      vii. Projects or relationships that have a community impact.

4. Authorized Signatories. The executive team members (Authorized Signatories) identified on Exhibit A have the authority, with respect to contracts, LOIs, LOAs and agreements that relate to functions and operations within their respective administrative and business units, to:
   a. Approve and execute such contracts, LOIs, LOAs and agreements, and
   b. Delegate approval and/or signatory authority to a subordinate director or manager, with any appropriate dollar-value, timeframe, contract-specific or other limitations they deem appropriate. Such delegation does not negate the requirement that all contracts, LOIs, LOAs or agreements require the review mandated by Section III.1. above.

5. Archiving Contracts. All contracts are maintained pursuant to SCFHP's Record Retention policy.

IV. References

CP.05 v1 Record Retention
FIN.03 Cash Disbursements

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
[Manager/Director Name] [Title] Date	[Compliance Approver Name] Title] Date	[Executive's Name] [Title] Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original			

POLICY

Policy Title:	**Corrective Actions**	**Policy No.:**	CP.07 v1
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Compliance	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒Medi-Cal	☒Healthy Kids	☒CMC

I. Purpose

The purpose of this policy is to establish the standards that Santa Clara Family Health Plan (SCFHP) utilizes to correct actual or potential non-compliance, fraud, waste and abuse (FWA) and/or unethical conduct, and to promote a culture of compliance and continuous improvement.

II. Policy

SCFHP issues corrective actions to internal business units, individuals, and/or first-tier, downstream and related entities (FDRs), as appropriate, upon the identification of non-compliance, unethical behavior or FWA to correct and prevent the issue(s) from recurring.

III. Responsibilities

1. Compliant activities and ethical behavior is the responsibility of all SCFHP employees, temporary staff, volunteers, interns, consultants and Governing Body members (Employees) and FDRs. Accordingly, the following are responsible for issuing, investigating, supporting and/or demonstrating remediation of corrective actions associated with potential non-compliance, unethical behavior or FWA:

    a. SCFHP managers and directors may issue corrective actions for their staff to resolve issues identified during regular monitoring;
    b. SCFHP's compliance department may issue corrective actions for internal business units, individuals and/or FDRs to resolve issues identified during regular monitoring, auditing or associated with regulatory reporting requirements that have not been met;
    c. The Compliance Committee may recommend the issuance of corrective actions based on their review of potential issues presented for their guidance and input;
    d. The Governing Body may request corrective actions based on the organization's overall financial or operational performance;
    e. SCFHP's Human Resources may issue performance improvement plans (PIPs), a form of corrective action, when it identifies systemic performance or behavioral issues demonstrated by employees; and

f. FDRs may issue corrective actions to its staff and/or downstream entities that support SCFHP's government-funded health care programs.

2. All SCFHP Employees and FDRs are responsible for participation in, and remediation of, any regulatory corrective actions issued by regulatory agencies to SCFHP.

IV. References

42 C.F.R. § 422.503(b)(4)(vi)(G)
42 C.F.R. § 423.504(b)(4)(vi)(G)
Medicare Managed Care Manual, Chapter 21, Section 50.7.2
Medicare Prescription Drug Benefit Manual, Chapter 9, Section 50.7.2

V. Approval/Revision History

First Level Approval	Second Level Approval	Second Level Approval
Ron Smothers Medicare Compliance Manager Date	Robin Larmer Chief Compliance & Regulatory Affairs Officer Date	Christine M. Tomcala Chief Executive Officer Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
V1	Original	Compliance Committee of the Board		

Santa Clara Family Health Plan™

Meeting Minutes
SCCHA Quality Improvement Committee
Wednesday, February 13, 2019 6pm

Voting Committee Members	Specialty	Present? Y or N
Nayyara Dawood, MD	Pediatrics	Y
Jennifer Foreman, MD	Pediatrics	Y
Jimmy Lin, MD	Internist	Y
Ria Paul, MD, Chair	Geriatric Medicine	N
Laurie Nakahira, DO, CMO	Pediatrics	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Jeffrey Arnold, MD	Emergency Medicine	Y
Christine Tomcala, CEO	N/A	Y

Non-Voting Staff Members	Title	Present? Y or N
Johanna Liu, PharmD	Director, Quality and Pharmacy	Y
Robin Larmer	Chief Compliance and Regulatory Affairs Officer	Y
Jeff Robertson, MD	Medical Director	N
Darryl Breakbill	Director, Grievance and Appeals Operations	N
Matthew Garduno	Data Analyst, Grievance & Appeals	Y
Mary Perryman	Supervisor, Grievance & Appeals	Y
Zara Hernandez	Coordinator, Quality Improvement	Y
Eric Tatum	Director, Provider Network Management	Y
Carmen Switzer	Provider Network Access Manager	Y
Mai Chang	Manager of Quality Improvement	Y
Chris Turner	Chief Operating Officer	N
Mansur Zahir	Project Manager, Process Improvement	Y
Jessica Bautista	Program Manager, Health Homes	Y

AGENDA ITEM	DISCUSSION/ACTION	ACTION	RESPONSIBLE PARTIES	DUE DATE
Introductions	Ria Paul, MD Chairman was absent so Laurie Nakahira, DO Chief Medical Officer (CMO) called the meeting to order at 6:09pm. Quorum was established at this time.			
Review and approval of December 5, 2018 meeting minutes	The minutes of the December 5th, 2018 Quality Improvement Committee meeting were reviewed. It was moved, seconded to approve minutes as written.	Minutes of the December 5th, 2018 meeting were approved as presented.		
Public Comment	No public comment.	No public comment.		
CEO Update	Christine Tomcala reported membership as of January 2019 is 251,000. There is a decline in Medi-Cal members, which is not specific to the Health Plan. The entire county is seeing this trend due to high-cost of living so people are moving out of county, undocumented members; and members are no longer eligible as they are above the income level. Ms. Tomcala indicated that the Health Plan will be undergoing audits with the Department of Managed Health Care (DMHC) and the Department of Health Care Services (DHCS). DMHC and DHCS will be onsite in March. The National Committee for Quality Assurance (NCQA) survey is underway for the Cal MediConnect (CMC) line of business. NCQA auditors were onsite for file reviews and the Health Plan hopes to have results soon. Membership as of January 2019 is 251,000 members. There has been a decline in Medi-Cal members, which is not specific to the Health Plan. The entire county is seeing this trend due to high living costs in the Bay Area. The Plan will be undergoing audits for CMC audit. Initial stages			

	for DHCS will be onsite in March. NCQA survey is underway for CMC LOB. Also came onsite and the HP hopes to have results soon. Ms. Tomcala also reported that O'Conner and St. Louise acquisition by the County has started but not definitive.			
Action Items A. Review of Quality Improvement Program Description 2019	Ms. Chang presented the Quality Improvement Program (QI) Description for 2019 (all attendees were given the program description as handouts): Ms. Chang described the following changes to the QI Program: • In Section I - Introduction, language was updated to include membership numbers for each line of business. • In Section XII - Organizational Structure, language was updated to include new positions and job descriptions of the QI Staff. • In Section XIII - Committee Structure Overview, Grievance and Appeals Review committee was removed from the organizational chart since they do not report to QIC. Consumer Advisory Board (CAB) was added as a reporting committee to QIC. • In Section XXI – Facility Site Review (FSR), Medical Records, and Physical Accessibility Review, language was updated to clarify the FSR process. The previous language was outdated. • In Section XVIII – Care of Members with Complex Needs, language was added to reference the Population Health Management Strategy document.	Upon motion dully made and seconded. Approved as presented.		

B. Review Health Education Program Description 2019, Work Plan 2019, and Evaluation 2018.	Ms. Shah presented an overview of Health Education's Work Plan for 2019, and Evaluation for 2018. Health Education Evaluation 2018**:** • Completed 4 contracts, working on renewing contracts with community partners. Added 2 new programs: YMCA for a Diabetes Camp for kids from grades K-10; Chronic Pain Management. class offered through the Health Trust. • Class audits were completed for 4 vendors. 2 vendors were not audited as they did not have any upcoming classes in 2018 in English. • Member incentive Programs: Health Education completed their Controlling Blood Pressure (CBP) incentive program for year 2017 and submitted an evaluation to the DHCS. Targeted incentive programs for hypertension, immunizations for Vietnamese children, pregnancy and diabetes were launched in 2018: Dr. Foreman inquired why the immunization incentive was only limited to Physicians Medical Group and Premier Care of Northern California. Ms. Shah stated this incentive is part of DHCS' Performance Improvement Projects (PIPs) surrounding disparities. Based on analysis of data, disparity existed for Vietnamese children in these two networks. Ms. Shah presented Health Education Program Description for 2019 and the Work Plan for 2019. Minor changes were made to the Program Description and added language about the CAB changes, but included text about Consumer Advisory Board (CAB). The Health Education Work Plan 2019:	Upon motion dully made and seconded. Approved as presented.		

	• Health Education will continue updating their contracts with vendors and expand class offerings. A comprehensive online health education resource library with materials that can be sent to members as well as providers is in progress. • New programs will be added: asthma medication, high blood pressure, well-woman visits (such as breast screenings), well-child visits, and diabetes. In addition, Health education plans to implement at least 2 additional programs to focus on health disparities. Ms. Larmer asked about childhood immunizations and if Ms. Shah knew what impact it's having on our members in this early stage. Ms. Shah explained that the impact has been minimal, as the target population is very small and only 20 forms have been received to date.			
C. Review Cultural & Linguistics (C&L) Description 2019, Work Plan 2019, and Evaluation 2018.	Ms. Shah presented an overview of Cultural & Linguistics (C&L) Description 2019, Work Plan for 2019, and Evaluation for 2018. C&L Program Evaluation 2018: • C&L added a new interpretation vendor, Hanna Interpretation Services, in response to a notice of noncompliance that was received from the DHCS for a French interpreter. • C&L focused efforts on updating the internal staff training to include info/resources on gender identity, sexual orientation, and health plan specific information. • C&L is working with IT to add a language attribute to QNXT, which is the company wide claims	Upon motion dully made and seconded. Approved as presented.		

	processing program as well as how calls with members are logged from Customer Service. 2019 Program Description: • Minor changes were made to the 2019 C&L Program. 2019 Work Plan: • C&L all-staff training. HR and the all-staff training were on two different platforms. The goal is to work to make it on a single platform. The Cultural Competency training will be sent to all staff in the next few weeks. • C&L will continue to monitor the Language Attribute project with IT for 3 months, and make any changes as necessary.			
D. Review Quality Improvement Policies	Dr. Liu presented QI policies: QI.05 – Potential Quality of Care Issues – no changes QI.07 Physical Access Compliance – no changes QI.10 IHA and IHEBA Assessments – no changes QI.28 Health Homes Program – this is a new program requirement through the State of CA which will go live in Santa Clara County on July 1, 2019. This is a new policy that will govern all of the procedures. There is also a 2nd launch date starting January 2020 for members with Serious Mental Illness (SMI). Health Homes Program is an intensive case management, care coordination and housing navigation program for Medi-Cal members who meet criteria from the state. SCFHP is working to credential a network of community	Upon motion dully made and seconded. Approved as presented.		

	based care management entities (CB-CMEs) to serve this population. Dr. Arnold asked if there is a scoring grid or way to identify which members qualify for this program. Dr. Liu clarified that the state provides specific criteria and the Health Plan is in the process of creating criteria. Dr. Liu stated that they are seeking clarification from the State on the final eligibility list, to ensure it's accurate. The list received from the State contained outdated data. There was a motion to approve from Dr. Nakahira, moved to second and approved as presented.			
E. American Disabilities Work Plan 2019	Ms. Chang presented the ADA Work Plan: The work plan monitors different metrics around patient safety, access, health education, grievance, and delivery of preventative care. It tracks any PQI (potential quality of care) or actual quality of care issues. The work plan lists all of these measures that will be tracked for the year, and Ms. Chang plans to bring back to the group any findings in 2020. There was a motion to approve from Dr. Nakahira, moved to second and was approved as presented.	Upon motion dully made and seconded. Approved as presented.		
F. Cal MediConnect Advisory Board (CAB) Charter	Dr. Liu presented the CAB Charter which would make it a subcommittee of the QIC. The Health Plan has always had a Cal MediConnect Consumer Advisory board (CAB) and is informally reported to the QIC. There is also a Medi-cal Consumer Advisory Committee (CAC) and that is a direct committee of the board. Dr. Liu stated that they wanted the same path for CAB to the committee as well for CMC members.	Upon motion dully made and seconded. Approved as presented.		

	The purpose of CAB is to give CMC members, their caregivers, and anyone that serves them in our community, a voice to the Health Plan ensuring the Health Plan understands their needs and are doing the best to meet them. There was a motion to approve from Dr. Nakahira, moved to second and was approved as presented.			
G. Timely Access and Availability Results	Ms. Switzer reported the Access and Availability survey results for measurement year 2018. The plan conducts 3 different access surveys per year as required by DMHS and DHCS. The Plan looks for opportunities to improve accessibility and results are prioritized into different action plans. PAAS- PCP results for scheduling - urgent care within 48 hours: 2018: 68% 2017: 72% means Change: -4%; goal not met. PCP for non-urgent/routing care scheduling within 10 business days: 2018: 90% 2017: 91% means Change: -1%; goal not met. Specialists for scheduling urgent visits within 96 hours: 2018 Cardiology: 71% 2017 Cardiology: 73 Result: -2%; Goal 100%, goal not met. 2018 Endocrinology: 53%	Upon motion dully made and seconded. Approved as presented.		

	2017 Endocrinology: 24% Result: Goal 100%, goal not met. 2018 Gastroenterology: 42% 2017 Gastroenterology: 13% Result: Goal 100%; goal not met. 2018 Psychology: 60% 2017 Psychology: 1% Result: Goal 100%; goal not met. Provider Group results for scheduling non-urgent visits within 15 business days: Cardiology: 70% compliance rate in 2018. -2% change from 2017. Goal is 100%; goal not met. Endocrinology: 50% compliance rate in 2018. 32% increase from 2017. Goal is 100%; goal not met. Gastroenterology: 30% compliance rate in 2018. 29% increase from 2017. Goal is 100%, goal not met. Psychology: 70% compliance rate in 2018. 69% increase from 2017. Goal is 100%, goal not met. *Non Physician Mental health - urgent care appts within 96 hours:* None of applied behavioral health met the standard of 100%, social workers met 67%. The goal for social workers is 100%. No results presented for psychology. *Non Physician Mental health - non urgent care within 15 business days:* Compliance for clinical social workers and marriage/family counseling were met at 100%, meeting			

	goal. No results were available for psychology and applied behavioral health had a compliance rate of 0% and did not meet the goal. *Ancillary providers:* These providers have met the standard the last 2 years, including 2018. The standard is to schedule within 15 business days. The second survey was presented for PCPs for after-hours. Providers must have an after-hours message on voicemail letting patients know what to do in case of an emergency. 480 providers were sampled. 100% of PCPs met this goal in 2018, a 12% increase from 2017. For providers who let patients know via voicemail that they will call them back within 30 minutes or less, only 44% of providers sampled (N=480) met this goal, a 30% decrease from 2017. SCFHP will be providing education on call-backs within 30 minutes as a focus point for measurement year 2019. The final survey was presented – Third Next Available Appointment (TNAA). *Table 1 shows the 3rd next avail appointment for new patients coming into the practice. 2 of these providers met the goal For 2018:* PCP – 0% compliance OBGYN – 50% compliance Dermatologists - 100% compliance Gastroenterologists – 100% compliance Otolaryngologists – 50% compliance Peds Neurologists – 0% compliance *For TNAA for established patients:* PCP – 80% compliance			

	OBGYN – 80% compliance Dermatologists - 100% compliance Gastroenterologists – 100% compliance Otolaryngologists – 50% Peds Neurologists – 0% compliance *Wait time for Return Call During Business Hours (non med related): Standard is 1 business day.* PCP – 100% compliance – met goal of 100% OBGYN – 60% compliance – did not meet goal of 100% Dermatologists - 100% compliance – met goal of 100% Gastroenterologists – 100% compliance – met goal of 100% Otolaryngologists – 100% - met goal of 100% Peds Neurologists – 100% compliance – met goal of 100% *Does Office have an After-Hours Message directing patients on how to access care?* All providers were in 100% of compliance, met 100% goal. *PAAS (Provider Appointment and Availability Survey).* This is re-surveying results for urgent and non-urgent appts. Resurvey results showed that approximately 65% of providers met the standards. Providers who showed continued non-compliance are required to complete SCFHP's access training program. Ms. Switzer discussed barriers/ opportunities/interventions related to the access and availability surveys: *1) Timely access for non-compliant providers*- Opportunity to improve access to urgent and non-urgent appts. The planned intervention is to improve training materials (completed) and conduct provider outreach (in process)			

	2) Lack of knowledge for access standards- Opportunity to educate providers on timely access standards. Intervention methods include improving training materials (completed) and conduct provider outreach (in process). *3) After-hours Access (return call within 30 minutes or less)* - Opportunity to improve after-hours access. Intervention methods include improving training materials (completed) and educating providers with SCFHP's Access Standards Grid. SCFHP's is researching using online webinars as a different training platform. Dr. Dawood inquired what methods are used to communicate with providers. Ms. Switzer stated that communication is done primarily through fax blast. Dr. Dawood stated that not all providers prefer faxing and suggested that SCFHP review annually with providers what the best mode of communication is (fax, email, phone, etc.).			
6a. Appeals and Grievances	Mr. Garduno presented the Appeals and Grievances report. There was a higher volume of grievances cases in July – Oct 2018 due to a number of no-shows and late arrivals for transportation for members. Total appeals from January 2018 – December 2018 were consistent, with the exception of a drop in appeals in September 2018. Total grievances from January 2018 – December 2018 also stayed consistent. Grievance has implemented a new	Upon motion dully made and seconded. Approved as presented.		

	program called Beacon, which will help streamline processes. Pharmacy appeals and medical appeals: Pharmacy usually has a higher overturn rate than medical appeals. Pharmacy's initial review timeframe is one business day, which leaves little time to request and submit information. CMC Rates per 1000: For January 2018 – December 2018, CMC appeals drastically dropped from 35 cases to 18 cases. The Appeals & Grievances Manager will conduct a root cause analysis to determine why this drop occurred. CMC Appeals by Determination: There is currently a higher volume of appeals that are still in process. Cases have 60 calendar days for processing. These cases need documentation and if the documentation comes in, the 60 calendar days reset and a case can be open for up to 120 days. Overall timeliness for Appeals & Grievances: Total California Home Medical Equipment (CHME) grievances for Healthy Kids/Medi-Cal membership: range from a low of 6 in February and June of 2018, to a high of 27 from August – October 2018. Total CHME grievances for CMC: Range from 4 in January 2018 – to a high of 25 in Sept. Total of 341 complaints filed since January 1, 2018. Appeals & Grievances was understaffed for part of 2018, and lost a member of their team in October. Since October, Appeals and Grievances have doubled in staff			

	and are implementing a new program (called Beacon) for tracking and monitoring timeliness of grievances.			
6B. VHP PQI Access Review	Ms. Chang presented access review for PQI (potential quality issues) related to Valley Health Plan: In Q3 and Q4 of 2018, there were 29 access-related PQI issues. 21 of these cases were related to members not being able to obtain appointments with their PCP or specialist. The highest number of specialty cases was for members who could not obtain appointments with dermatologist at 28.6%. SCFHP Quality met had two meetings with VHP quality team to discuss this issue. They shared this information, along with the timely access standards. The resolutions are as follows: • 9 cases were referred to an out of network provider or were able to obtain an earlier appointment after filing a grievance. • 2 members switched PCPs. • 2 members were referred to urgent care. • Other cases were reviewed by CMO and was determined that the wait time for the appointments were appropriate based on the condition of the member. The Medical Director recommended that SCFHP discuss these PQI cases with Valley Health Plan to understand how access-related issues are resolved and how members are triaged. No Corrective Action Plan was given to Valley Health Plan at this time. The Quality Improvement team will continue to monitor any PQIs related to access.	Upon motion dully made and seconded. Approved as presented.		

	Dr. Foreman inquired as to why there is a higher number of cases regarding Dermatologists. Ms. Chang stated that the plan always seen a higher number of complaints with this specialty. Most of the community clinics are now on E-Consult and the dermatology specialty has recently been added to the program.			
6C. QIC Charter Review	Dr. Liu presented the QIC Charter: The QIC Charter is being presented for review due to the Cal MediConnect CAB being added as a subcommittee to the QIC. Additionally, Dr. Liu recommended amending language in the QIC Charter under 'Meetings' – which states that committee members must attend at least 2 meetings per year. The change should state that "committee members must attend at least 50% of meetings in a calendar year." After the QIC approves the changes, the revised QIC Charter will be sent to the Governing Board for final approval.	Recommended changes will be presented to the Governing Board as appropriate.		
7a. Credentialing Committee	Dr. Nakahira presented a summary of the December 12, 2018 Credentialing Committee report. Two initial providers were credentialed. 29 providers were re-credentialed. There were no terminations, suspensions, rejections or denials. The Health Plan has a total 265 providers (excludes delegates) as of November 30, 2018.	Approved as presented		
7b. Pharmacy & Therapeutics Committee	Dr. Lin presented summary of the September 20, 2018 Pharmacy & Therapeutics (P&T) Committee. Pharmacy appeals & grievances for Q3 2018 was presented. There were no changes to charter. Updates were made to the Hepatitis C policy. The age requirement is 12 years or	Approved as presented		

	older and no longer looking at fibrosis score. For state covered drugs, the Plan will apply transition of care logic to non-Part-D drugs. Opioid Strategy was presented.			
7c. Utilization Management Committee	Dr. Lin presented summary of October 17, 2018 Utilization Management (UM) Committee report. 2019 Prior Authorization grid was reviewed. The new grid combines all lines of businesses with a separate grid for medications. Cal MediConnect 2017 Program Evaluation was presented and approved. Dashboard metrics and standard Utilization metrics were presented. Quality Monitoring Report for Q3 2018 was also presented.	Approved as presented		
7d. Compliance Report	Ms. Larmer presented the Audit Overall Work Stream Status tracker. This lists all of the business units that may have had a compliance risk and any corrective actions. Many corrective actions center around Grievance & Appeals and authorizations. Grievance & Appeals is a critical risk area, and an area sited in Audit Findings. Next steps: all corrective actions that were submitted have been accepted by CMS. The Health Plan will need to evaluate corrective actions by July 31st and Ms. Tomcala will need to attest that these conditions and actions were completed.			
7e. Quality Dashboard	Dr. Liu presented the Quality Improvement dashboard. PQI issues dashboard – a number of cases (about 70) are overdue. Usually these are processed within 60 days. QI is working through the backlog of these cases. Reasons for the overdue cases is due to staff turnover and internal interpretation via clinical reviewers. Clarification was provided to clinical reviewers to streamline review process and QI has also hired temporary staff to help ensure these cases are being processed timely.			

	Facility Site Review (FSR) – total of 5 were completed in Q4 2018 with 100% of the sites reviewed in a timely manner. Quality Projects – Controlling High Blood Pressure – 986 eligible, 36 received actual incentive = 4% Childhood Immunizations – 350 eligible, 18 received incentive = 5% Comprehensive Diabetes Screening – 212 eligible, 13 received incentive = 6% Prenatal – 59 received gift card, 31 received car seat, 40 received sleep pod. Initial Health Assessment (IHA) –1112 members eligible for IHA in Q4 2018. 47.5% completed IHAs within 120 days of member's enrollment into the Health Plan. The Committee discussed whether members who have a lapse in Medi-Cal coverage are assigned to the same provider after re-enrolling with the Health Plan. Dr. Foreman indicated that when she spoke with the Plan she was advised that if the lapse was over a certain amount of months, the member is not assigned to the same person. Dr. Foreman stated she does not know what the HP defines as a "new" member. Ms. Tomcala stated that it's up to the state to define what "new" means and that per the Health Plan's algorithm, if a member comes back after having a lapse, the Plan should be looking at who they saw before and assigning them to the same provider. Dr. Dawood indicated her practice has experienced situations where a member had a lapse in coverage, comes back, and is not reassigned to the same provider. This causes front office staff to scramble and work with the Health Plan to fix the issue so that the member can be			

	seen. The Health Plan tries to maintain the same provider and Ms. Tomcala asked Dr. Dawood to provide examples of patients with this situation for further research by the Health Plan Final housekeeping item: Previous meetings were held at 6:30pm. Dr. Liu asked the Committee members if they were in agreement to continue meetings at 6pm -8pm. There was agreement and future agendas and invites will be updated as appropriate.			
Adjournment	Meeting adjourned by Dr. Nakahira at 7:56pm			
Next Meeting	Wednesday, April 10th at 6pm	Calendar and attend.	All	

Reviewed and approved by:

_____ Date _____
Ria Paul, MD
Quality Improvement Committee Chairperson

Health Education

2018 Evaluation

1. Health Education Programs
   - Contracts – 4 completed
   - New programs – 2 added
   - Class Audits – 4 vendors audited
2. Member Incentives
   - Evaluation for CBP 2017 submitted
   - Programs initiated: high blood pressure, childhood immunizations, diabetes nephropathy, and prenatal care

Program Description

- Added information about Consumer Advisory Board

2019 Work Plan

1. Health Education Programs
   - Contracts - 4 remaining
   - Add new programs
   - Patient education library
2. Member Incentives
   - Ending programs: high blood pressure, childhood immunizations, diabetes nephropathy.
   - Ongoing programs: prenatal care
   - New programs: Asthma medication, high blood pressure, well woman, well-child, and diabetes
   - Implement at least 2 additional programs focused on health disparities.

Santa Clara Family Health Plan

Health Education Program

2019

2019 HEALTH EDUCATION PROGRAM

TABLE OF CONTENTS

I. INTRODUCTION

Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP), is a county public health agency. SCFHP's primary mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with providers, SCFHP acts as a bridge between the health care system and those who need coverage.

SCFHP is a fully licensed health care service plan, which began operations in February 1997. SCFHP initially served the County's Medi-Cal population, as a Medi-Cal managed care plan in the State's "Two Plan Model Program". SCFHP continues to serve as the county local initiative in that program. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program. In 2015, SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) for the Cal MediConnect (CMC) Duals Demonstration Project.

Through dedication to integrity, outstanding service, and care for our community, we work to ensure that everyone in our county can receive the care they need for themselves and for their families.

II. STATEMENT OF PURPOSE

The purpose of the Health Education Program is to deliver general health education, health promotion, and patient education to assist SCFHP beneficiaries to maintain and improve their health and manage their illnesses. SCFHP's Health Education Program complies with the Health Education requirements outlined in the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS.. The Health Education Program supports SCFHP's Population Health Management (PHM) strategy.

III. PROGRAM SCOPE

The Health Education Program provides organized programs, services, functions, and resources necessary to deliver health education, health promotion, and patient education. It includes assessment, monitoring, and evaluation of all services provided by SCFHP and contracted Vendors.

IV. PROGRAM GOALS AND OBJECTIVES

Health Education

- Keeping beneficiaries healthy through appropriate use of health care services, including: preventive and primary health care, obstetrical care, health education services, and complementary and alternative care.

- Managing beneficiaries with emerging risk through risk reduction and healthy lifestyles, including: tobacco use and cessation, alcohol and drug use, injury prevention, prevention of sexually transmitted diseases, HIV and unintended pregnancy, nutrition, weight control, and physical activity, and parenting.
- Managing multiple chronic illnesses through self-care and management of health conditions, including: pregnancy, asthma, diabetes, and hypertension.
- Beneficiaries receive point of service education as part of preventive and primary health care visits.
    - Education, training, and program resources will be given to assist contracted medical providers in the delivery of health education services for beneficiaries.
- Provide provider education regarding the Initial Health Assessment (IHA) and the need for beneficiaries to have an IHA within 120 days of being eligible with the health plan.

V. PROGRAM STRUCTURE AND ORGANIZATION

The Health Education Program is under the direction of a full-time health educator with a Master's degree in Public Health with specialization in health education

The Health Education Program is part of the Quality Improvement Department. Health Education Program activities will be coordinated and integrated with SCFHP's overall PHM strategy and quality improvement plan.

VI. PROGRAM IMPLEMENTATION

Health Education Classes

The Health Education Department will provide programs, classes and/or materials free of charge to beneficiaries including, but not limited to, the following topics:

1. Nutrition
2. Healthy weight maintenance and physical activity
3. Individual and group counseling and support services
4. Parenting
5. Smoking and tobacco use cessation
6. Alcohol and drug use
7. Injury prevention
8. Prevention of sexually transmitted diseases, HIV and unintended pregnancy
9. Chronic disease management, including asthma, diabetes, and hypertension
10. Pregnancy care

SCFHP also offers other self-management tools through the Member Portal.

Point of Service Beneficiary Education

Individual beneficiaries will receive point of service health education as part of their preventive and primary health care visits. Health risk behaviors, health practices and health education needs related to health conditions are identified. Educational intervention, including counseling and referral for health education services will be conducted and documented in the beneficiary's medical record (DHCS PL 02-004).

Provider Education and Training

SCFHP will provide education, training, and program resources to contracted medical providers and other allied health care providers to support delivery of effective health education services for beneficiaries.

Provider training will cover:

1. Group Needs Assessment findings
2. Initial Health Assessment (IHA) and Staying Healthy Assessment (SHA) requirements
3. Techniques to enhance effectiveness of provider/patient interaction
4. Educational tools, modules, materials and staff resources
5. Plan-specific resource and referral information
6. Health Education requirements, standards, clinical practice guidelines, and monitoring

Medical providers will use the Staying Healthy Assessment (SHA) tool and other relevant clinical evidence to identify beneficiary's health education needs and conduct educational intervention. SCFHP will provide resource information, educational material and other program resources to assist contracting medical providers to provide effective health education services for beneficiaries. (DHCS PL 02-004)

SCFHP will ensure contracted providers are trained and administering the Initial Health Assessment (IHA) with the SHA for all beneficiaries within 120 days of enrollment.

SCFHP will ensure contracted providers have the preventative care disease-specific and plan services information necessary to support beneficiary education in an effort to promote compliance with treatment directives and to encourage self-directed care.

SCFHP will also implement a comprehensive risk assessment tool for all pregnant female beneficiaries that is comparable to the ACOG standard and Comprehensive Perinatal Services Program (CPSP) standards per Title 22 CCR Section 51348. The results of this assessment shall be maintained as part of the obstetrical record and shall include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool shall be administered at the initial prenatal visit, once each trimester thereafter and at the postpartum visit. Risks identified shall be

followed up on by appropriate interventions, which must be documented in the medical record. (DHCS PL 08-003)

VII. PROGRAM EFFECTIVENESS AND ACCOUNTABILITY

Program Standards, Evaluation, Monitoring, and Quality Improvement
SCFHP shall ensure the organized delivery of Health Education Programs using educational strategies and methods that are appropriate for beneficiaries and effective in achieving behavioral change for improved health.

The Health Education Program will be conducted according to the highest standards/guidelines supported by professional experts or peers, best practices, and/or published research findings. Appropriate levels of training, evaluation, e.g. formative, process, impact and outcome evaluation will be conducted to ensure effectiveness in achieving Health Education Program goals and objectives. Policies and procedures will be in place for ensuring providers receive training on a continuing basis regarding DHCS developed cultural awareness and sensitivity instruction for Senior and Persons with Disability (SPD) beneficiaries.

Monitoring
SCFHP will monitor the performance of providers contracted to deliver Health Education Programs and services to beneficiaries. Strategies will be implemented to improve provider performance and effectiveness (SCFHP/Medi-Cal contract Exhibit A, Attachment 10 Scope of Services).

Facility Site Reviews
The Quality Improvement Department monitors PCP's IHA and SHA process during periodic site reviews. Facility Site Reviews (FSR) will include medical chart reviews to monitor if providers are compliant with IHA requirements. IHA requirements will be included in providers' corrective action plans (CAP) for providers not passing any section of their FSR's.

Group Needs Assessment
A group needs assessment (GNA) will be conducted every 3 years or as often as required by DMHC or DHCS to identify the health education and cultural and linguistic needs of our beneficiaries. Multiple reliable data sources, methodologies, techniques, and tools will be used to conduct the GNA. The findings will be utilized for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Documentation will be maintained of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the beneficiary population.

Population Assessment

SCFHP annually assesses the characteristics and needs, including social determinants of health, of its beneficiary population. This includes review of relevant beneficiary sub-populations, child and adolescents, beneficiaries with disabilities, and beneficiaries with serious and persistent mental illness.

SCFHP annually uses the population assessment to review and update its Population Health Management activities, resources, and community resources for integration into program offerings to address beneficiary needs.

Community Advisory Committee

SCFHP shall form a Community Advisory Committee (CAC) pursuant to Title 22 CCR Section 53876(c) that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers. SCFHP will ensure CAC is included and involved in policy decisions related to Quality Improvement educational, operational, and cultural competency issues affecting groups who speak a primary language other than English.

Community Advisory Board

SCFHP shall form a Cal MediConnect Consumer Advisory Board (CAB) as required by the California Coordinated Care Initiative. SCFHP will ensure the CAB engages consumers and caregivers in the implementation and evaluation of operations and policies of SCFHP Cal MediConnect Plan. SCFHP shall regularly update CAB members on key changes to the SCFHP Cal MediConnect operations or mission. (CMC 3-Way Contract, p. 115, 2.16.3.2.4.5)

VIII. CONFIDENTIALITY AND CONFLICT OF INTEREST

Confidentiality of practitioner, provider, and beneficiary identifying information is ensured in the administration of Health Education Services.

HEALTH EDUCATION WORK PLAN 2019

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Pregnant Women	Pg. 73 Exhibit A, Attachment 10 Scope of Services	- Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	- Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services	Annually	Continuous	
Services for All Members	Health Education	- Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS PL 02-004	- Provide health education programs and services at no charge to Members directly and/or thru Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships - Develop patient education materials library	- P&P's for health education system - List of health ed classes that cover all required health ed topic areas. - Provider/Vendor Contracts/MOU's - Comprehensive patient education library	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	
Services for All Members	Health Education	Ensure effective health ed program	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS APL 17-002	- Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	- Use findings from GNA to select educational strategies and methods - Measure pre and post educational intervention behavior	- P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator	Annually	Continuous	
Services for All Members	Health Education		DHCS APL 18-016	- Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	- Test reading materials using flesch readability formula, etc., - Field test material at CAC meetings	- P&P's that define appropriate reading levels - Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to plan developed health education materials)	100%	Health Educator	Ongoing	Continuous	
NCQA	Health Ed		Pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2018 Health Plan Accreditation Requirements PHM4	- Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions - Alcohol and drug use, including avoiding at risk drinking - Identifying depressive symptoms	- Contract with health education vendors to provide classes to meet requirement	- Health Ed courses/activities - Health Educator or designee to audit all health education classes	- 100% of vendors to have signed contracts (new or renewed) by 12/31/2019 - 100% of vendors audited by 12/31/19	Health Educator	Annually	Continuous	

HEALTH EDUCATION WORK PLAN 2019

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Member Services	Health Ed	Member Services	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials.	- Written Member informing materials will be translated into identified threshold and concentration languages.	- P&P's for providing communication access to SPD beneficiaries in alternative formats or thru other methods that ensure communication - P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator	Annually	Continuous	
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.	All members informed	Marketing, Health Educator	Annually	Continuous	
Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004 DHCS PL 99-003 CMC 3-way contract 2.9.10.10	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services and culturally competent care for members. Training content shall include: language access requirements, tips for working with interpreters, cross-cultural communications, strategies to address health literacy, health beliefs, strategies for working with LEP members and SPDs, and disability sensitivity.	- Practitioner education and training by provider services - Health ed updates during JOC's	- Sign in sheet of provider training - JOC minutes	All providers trained	Health Educator, Provider Services, QI	Ongoing	Continuous	
Incentives	Health Ed	MMCD on-going monitoring activities	DHCS APL 16-005	Evaluation summary	- Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	- Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation/update summary	Health Educator	45 days after end of program incentive	Continuous	
Incentives	Health Ed	- Justify continuation of on-going incentive program	DHCS APL 16-005	Justify continuation of MI program	- Provide brief explanation (update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded in the previous year.	-Update submission to DHCS	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	

HEALTH EDUCATION WORK PLAN 2019

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials	- Ensure member informing resources are at sixth grade level or lower and translated into threshold languages	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower	Health Educator and Marketing	Ongoing	Continuous	
Health Education		Written Health Education Materials	DHCS APL 18-016	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using Readability and suitability checklist by qualified health educator	- Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	- For previously approved material, review every three years	Continuous	
Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2018 Health Plan Accreditation Requirements PHM4	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	- Develop an evaluation tool/survey	- Evaluation results summary	Baseline	Health Educator	Every 36 months	Continuous	
Health Education		Review plan's online web-based self-management tools.	NCQA 2018 Health Plan Accreditation Requirements PHM 4	To ensure online web-based self-management tools are up to date	- Review and update online web-based self-management tools including the plan website and portal	- Updated web-based self-management tools	Baseline	Health Educator	Ongoing	Continuous	
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	Pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	Ensure member medical records include health education behavioral assessment and referrals to health education services		- P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI Nurse	Annually	Continuous	
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	Pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	- Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide	- Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator	Annually	Continuous	

HEALTH EDUCATION WORK PLAN 2019											
Scope	**Area**	**Objective**	**Contract Reference**	**Project Objectives**	**Activity**	**Final Deliverable(s)**	**Goals or Baseline**	**Responsible Position**	**Reporting Frequency**	**Target Completion**	**Completed**
Quality of Services	Access and Availability	Create Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability DHS APL Policy Letter 17-002		- Incorporate GNA findings and annual and ongoing review of data into work plan - Approval of Health Ed Workplan by QI Committee - Submit Health Ed Workplan to MMCDHealthEducationmailbox@dhcs.ca.gov	- Approved Health Ed Workplan - See QI Work Plan for projects focusing on priorities areas	Baseline	QI Manager and Health Educator	Annually	July '19	
Quality of Services	Access and Availability	Health Disparities	Pg. 73 Exhibit A, Attachment 10 Scope of Services	Develop interventions based on identified health disparities	Implement at least 2 new projects outside of required DHCS PIPs and other government mandated projects.	- DHCS member incentive form submissions - Intervention work plan - intervention materials	Baseline	QI Manager, Health Educator	Annually	Continuous	
Community Advisory Committee	Access and Availability	Community Advisory Committee	Pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, APL 17-002	- Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from GNA findings.	- CAC Meeting minutes - Report GNA findings to CAC	Baseline	QI, Health Educator, and Marketing	Quarterly	Continuous	

HEALTH EDUCATION EVALUATION 2018

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Scope of Services	Scope of Services	Pregnant Women	Pg. 73 Exhibit A, Attachment 10 Scope of Services	- Implement risk assessment tool for pregnant female members which shall include health education needs risk assessment components	- Chart audits and provider training	- Provider Training and FSR results	All providers trained	QI & Health Educator, Provider Services	Annually	Continuous	Risk Assessment Tool implemented in 2016
Services for All Members	Health Education	- Implement and maintain a health education system that provides health education, health promotion and patient education for all members.	Pg. 73 Exhibit A, Attachment 10 Scope of Services DHCS PL 02-004	- Provide health education programs and services at no charge to Members directly and/or through Subcontracts or other formal agreements with providers.	- Take inventory of health ed vendor contracts - Contact community organizations for potential health ed partnerships	- P&P's for health education system - List of health ed classes that cover all required health ed topic areas. - Provider/Vendor Contracts/MOU's	Baseline	Health Educator	Review at least annually to ensure appropriate allocation of health resources.	Continuous	Policy QI.09 & Procedure QI.09.01 approved by QIC on 6/6/18 Contracted with YMCA for Diabetes Prevention Camp
Services for All Members	Health Education	Ensure effective health ed program	Pg. 61 Exhibit A, Attachment 9 Access and Availability, DHS APL Policy Letter 17-002	- Ensure organized delivery of health education programs using educational strategies and methods appropriate for Members and effective in achieving behavioral change.	- Use findings from GNA to select educational strategies and methods - Measure pre and post educational intervention behavior	- P&P's for delivery of health ed program using educational strategies appropriate for Members. -Health Education Program	Organized delivery of health ed program	Health Educator	Annually	Continuous	Policy QI.09 & Procedure QI.09.01. Ongoing search for new classes to add to current offerings. Class audits
Services for All Members	Health Education		DHCS APL 11-018	- Ensure health ed materials are written at sixth grade reading level and are culturally and linguistically appropriate for the intended audience.	- Test reading materials using flesch readability formula, etc., - Field test material at CAC meetings	- P&P's that define appropriate reading levels - Approved Readability and Suitability Checklists with attached Health Ed materials. (Only applies to materials in current use)	100%	Health Educator	Ongoing	Continuous	Readability and Suitability checklist completed for all member materials developed. No field testing needed for 2018.
NCQA	Health Ed		Pg. 73 Exhibit A, Attachment 10 Scope of Services, DHS PL 02-004 NCQA 2018 Health Plan Accreditation Requirements PHM4	- Contractor shall maintain a health ed system that provides educational intervention addressing: a)appropriate use of health care services, b)Risk-reduction and healthy lifestyles, and c)Self-care and management of health conditions - Alcohol and drug use, including avoiding at risk drinking - Identifying depressive symptoms	- Contract with health education vendors to provide classes to meet requirement	- Health Ed courses/activities - Health Educator or designee to audit all health education classes	- 75% of vendors to have signed contracts (new or renewed) by 12/31/2018 - 100% of vendors audited by 12/31/18	Health Educator	Annually	Continuous	5 contracts completed (Healthier Kids Foundation, Breathe California, Health Trust, Solera Health Network, and YMCA) Health Trust, Healthier Kids Foundation, Indian Health Center, ACT for Mental Health were audited in 2018. Edifying Lives and Breathe California were not audited in 2018 because they didn't have many classes scheduled for 2018.
Member Services	Health Ed	Member Services	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials.	- Written Member informing materials will be translated into identified threshold and concentration languages.	- P&P's for providing communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication - P&P's regarding the development content and distribution of Member information.	All informing materials at sixth grade reading level or lower and translated in threshold languages	Marketing, Health Educator	Annually	Continuous	P&P QI.08.04 Standing Requests for Member Materials in Alternate Formats P&P QI.09.01 QI.09.01 Health Education Program and Delivery System Procedure

HEALTH EDUCATION EVALUATION 2018

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Member Services	Health Ed	Inform members of their rights	CMC Appendix B: Enrollee Rights	Inform members of their rights in CMC Appendix B	Inform members in writing of their rights annually	Written policies regarding Enrollee rights specified in this appendix as well as written policies specifying how information about these rights will be disseminated to Enrollees.	All members informed	Marketing, Health Educator	Annually	Continuous	Member rights and responsibilities listed in Member Handbook page 142
Provider Training	Health Ed	Practitioner Education and Training	DHCS PL 02-004	Ensure education and training of contracting medical practitioners and other allied health care providers to support delivery of effective health education services for members.	- Practitioner education and training by provider services - Health ed updates during JOC's	- Sign in sheet of provider training - JOC minutes	All providers trained	Health Educator, Provider Services, QI	Ongoing	Continuous	Ongoing certification of training logs by Provider Network Management
Incentives	Health Ed	MMCD on-going monitoring activities	DHCS APL 16-005	Evaluation summary	- Plans must submit a brief description of evaluation results within 30 days after the incentive program ends	- Brief description of evaluation results indicating whether the program was successful.	All MI incentives with evaluation/update summary	Health Educator	45 days after end of program incentive	Continuous	Controlling High Blood Pressure (CBP) 2017 evaluation submitted 1/25/19. Submission delayed due to data collection and evaluation.
Incentives	Health Ed	- Justify continuation of on-going incentive program	DHCS APL 16-005	Justify continuation of MI program	- Provide brief explanation (update) of effectiveness and/or success rate of the incentive as well as total number of incentives that were awarded In the previous year.	-Update submission to DHCS	All continuous MI incentives with justification	Health Educator	Update must be submitted on annual basis; the first update is due within one year of the original approval date.	Continuous	Diabetes Nephropathy Screening (CDC-N) incentive submitted to DHCS for Q4 2018, Q1 and Q2 2019 implementation.
Website	Health Ed and C&L	Health Ed and member informing resources on SCFHP website are easy to read and translated into the threshold languages	Pg. 101 Exhibit A, Attachment 13 Member Services	- Written Member informing materials shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions - Address appropriate reading level and translation of materials	- Ensure member informing resources are at sixth grade level or lower and translated into threshold languages	- Translated and readable member informing materials	All Member informing resources translated in threshold languages at sixth grade reading level or lower	Health Educator and Marketing	Ongoing	Continuous	Member newsletters Translated Health Ed referral forms on website
Health Education		Written Health Education Materials	DHCS APL 11-018	To follow provisions in plan letter so that Member health education materials can be used without obtaining MMCD approval	- Approve written member health ed materials using Readability and suitability checklist by qualified health educator	- Approved Readability and Suitability Checklists with attached health ed materials.(Only applies to materials in current use)	Approved Readability and Suitability Checklists with attached health ed materials	Health Educator	- For previously approved material, review every three years	Continuous	Readability and Suitability checklist completed for all member materials developed. No field testing needed for 2018.
Health Education		Evaluation of Plan's self-management tools for usefulness to members	NCQA 2018 Health Plan Accreditation Requirements PHM4	To ensure self-management tools are useful to members and meets the language, vision, and hearing needs of members	- Develop an evaluation tool/survey	- Evaluation results summary	Baseline	Health Educator	Every 36 months	Continuous	Ongoing
Health Education		Review plan's online web-based self-management tools.	NCQA 2016 Health Plan Accreditation Requirements PHM 4	To ensure online web-based self-management tools are up to date	- Review and update online web-based self-management tools including the plan website and portal	- Updated web-based self-management tools	Baseline	Health Educator	Ongoing	Continuous	Ongoing

HEALTH EDUCATION EVALUATION 2018

Scope	Area	Objective	Contract Reference	Project Objectives	Activity	Final Deliverable(s)	Goals or Baseline	Responsible Position	Reporting Frequency	Target Completion	Completed
Quality of Services	QIS	Ensure medical records reflect all aspects of patient care.	Pg. 27 Exhibit A, Attachment 4 Quality Improvement System, pg. 140 Exhibit A, Attachment 18 Implementation Plan and Deliverables	- Ensure member medical records include health education behavioral assessment and referrals to health education services		- P&P ensuring provision of Initial Health Assessments (IHA) for adults and children, including IHEBA of the IHA. - Provide list and schedule of health ed classes and/or programs to providers	All providers trained on available health ed classes and programs	Provider Services, QI Nurse	Annually	Continuous	All Health ed classes are listed on the Provider Portal
Quality of Services	Access and Availability	Ensure members of childbearing age have access to out of plan family planning providers to temporarily or permanently prevent or delay pregnancy.	Pg. 57 Exhibit A, Attachment 9 Access and Availability	Ensure members of childbearing age have access to Health education and counseling necessary to make informed choices and understand contraceptive methods	- Inform Members in writing their right to access any qualified family planning provider without prior authorization in its Member Services Guide.	- Written information in Evidence of Coverage	All members of childbearing age informed of right to access to qualified family planning provider	Marketing and Health Educator	Annually		Information included in the Medi-Cal Evidence of Coverage. Members can call California Family Planning Information and Referral Service at 1-800-942-1054 to learn more.
Quality of Services	Access and Availability	Create Health Ed Work plan	Pg. 61 Exhibit A, Attachment 9 Access and Availability, DHS APL Policy Letter 17-002		- Incorporate GNA findings and annual and ongoing review of data into work plan - Approval of Health Ed Workplan by QI Committee - Submit Health Ed Workplan to MMCDHealthEducationmailbox@dhcs.ca.gov	- Approved Health Ed Workplan	Baseline	QI Manager and Health Educator	Annually	July '18	Work plan approved by QIC on 2/21/18
Community Advisory Committee	Access and Availability	Community Advisory Committee	Pg. 64 Exhibit A, Attachment 9 Access and Availability , MMCD PL 99-01, APL 17-002	- Have a Community Advisory Committee in place that will implement and maintain community partnerships with consumers, community advocates, and Traditional and Safety-Net providers.	- Ensure CAC is included in policy decisions for QI educational, operational and cultural competency issues from GNA findings.	- CAC Meeting minutes - Report GNA findings to CAC	Baseline	QI, Health Educator, and Marketing	Quarterly	Continuous	Ongoing

Cultural and Linguistics

2018 Evaluation

1. Interpreter Services
   - Monitoring new vendor
2. C&L All Staff Training
   - Updated to include information and resources on gender identity, sexual orientation, and health plan specific information
3. QNXT Language Attribute
   - All changes implemented in QNXT as of December 2018

Program Description

- Added information about Consumer Advisory Board

2019 Work Plan

1. C&L All Staff Training
   - New hire training and all staff training are different.
   - Develop a new training to streamline information
2. QNXT Language Attribute
   - Develop new process
   - Train all business units
   - Monitor for 3 months
   - Revise process

CULTURAL AND LINGUISTIC SERVICES PROGRAM 2019

I. INTRODUCTION

The Santa Clara County Health Authority, dba Santa Clara Family Health Plan (SCFHP), is a county public agency. SCFHP's primary mission is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with providers, SCFHP acts as a bridge between the health care system and those who need coverage.

SCFHP is a fully licensed health care service plan, which began operations in February 1997. SCFHP initially served the County's Medi-Cal population, as a Medi-Cal managed care plan in the State's "Two Plan Model Program". SCFHP continues to serve as the county local initiative in that program. In 2001, SCFHP also began providing health care to children enrolled in the Healthy Kids Program. In 2015, SCFHP contracted with Centers for Medicare and Medicaid Services (CMS) for the Cal MediConnect (CMC) Duals Demonstration Project.

Through dedication to integrity, outstanding service, and care for our community, SCFHP works to ensure that everyone in our county can receive the care they need for themselves and their families.

II. STATEMENT OF PURPOSE

The Cultural and Linguistic (C&L) Services Program is designed to improve access and eliminate disparities in quality of care for individuals with limited English proficiency (LEP), diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity. It also ensures that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner. (DHCS Medi-Cal Contract Exhibit A, Attachment 4, 7.F)

SCFHP is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries with LEP or sensory impairment. SCFHP's Cultural and Linguistic Services comply with 42, C.F. R. Section 440.262; Title VI of the Civil

Rights Act of 1964; (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) and the Cultural and Linguistic Services requirements in accordance to the contractual agreement with the

Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and CMS. The goal of the C&L Services Program is to ensure that SCFHP beneficiaries, especially LEP and sensory impaired beneficiaries receive equal access to health care services that are culturally and linguistically appropriate.

III. METHODOLOGY

Culturally and Linguistically Appropriate Services (CLAS) Standards

The Office of Minority Health (OMH) in the U.S. Department of Health & Human Services (DHHS) require that health care professionals and organizations take responsibility for providing culturally and linguistically appropriate services (CLAS) as a means to improve health care access, quality of care and health outcomes. Defining CLAS as "health care services that are respectful of and responsive to cultural and linguistic needs," the OMH has issued a set of 14 CLAS standards that include "mandates, guidelines and recommendation intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate services." [1]

SCFHP has chosen the 14 National CLAS Standards as the guiding principles of our C&L Services Program.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (4-7) and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: federal mandates, guidelines (recommended by OMH to be federal mandates) and recommendations. Standards 4-7 are mandates, Standards 1-3 and 8-13 are guidelines and Standard 14 is a recommendation. The CLAS standards are:

Culturally Competent Care

1. Health care organizations should ensure that patients/consumers receive from all staff effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

[1] DHHS, OMH, National Standards for CLAS, 2001.

3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate services delivery.

Language Access Services

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Organizational Supports for Cultural Competence

8. Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
11. Health care organizations should maintain a current demographic, cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to

13. Facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
14. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by patients/consumers.
15. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

IV. GOALS, STRATEGIES AND OBJECTIVES

The goal of the SCFHP C&L Services Program is to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with LEP, sensory impairment, diverse cultural and ethnic backgrounds, and disabilities, regardless of gender, sexual orientation or gender identity.

The Program ensures that beneficiaries have access to covered services delivered in a manner that meets their needs. It also ensures processes and procedures are designed to ensure that all medically necessary covered services are available and accessible to all beneficiaries regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability. The program formalizes ongoing efforts to provide CLAS at all clinical and administrative points of contact in a consistent and measurable fashion. Since the effort to provide culturally and linguistically competent care is an on-going process, the C&L Services staff periodically identifies new objectives and activities based on the findings of the Health Education and C&L Group Needs Assessment (GNA) which is administered every three (3) years or as often as required by DMHC or DHCS. SCFHP also incorporates beneficiary, provider and staff feedback expressed at Consumer Advisory Committee (CAC), Consumer Advisory Board (CAB), Provider Advisory Committee (PAC), and Quality Improvement Committee (QIC) meetings, area demographic research and organizational priorities into the development of its C&L Services Program.

An illustration of the reporting relationships for SCFHP identifies key staff with overall responsibility for the operation of the C&L Services Program (Appendix A).

SCFHP's Executive Team and Compliance Departments are responsible for promoting a culturally competent health care and work environment for SCFHP. They ensure that all Plan policies and procedures for eligible beneficiaries or potential enrollees do not discriminate due to race, color, national origin, creed, ancestry, religion, language, age,

gender, marital status, sexual orientation, health status or disability. They also ensure SCFHP's policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.

The Quality Department is responsible for developing, implementing and evaluating SCFHP's C&L Services Program in coordination with the Provider Network Management, Customer Service, Marketing and Communications, Health Services and Compliance Departments.

The Provider Network Management Department is responsible for ensuring that the composition of the provider network continuously meets beneficiaries' ethnic, cultural and linguistic needs of its beneficiaries on an ongoing basis (DHCS Medi-Cal Contract, Exhibit A, Attachment 6, 13). Language capabilities of clinicians and other provider office staff are identified during the credentialing process and through periodic surveys to update SCFHP's provider directory. Provider Network Management is also responsible for conducting initial and periodic provider network C&L training, as well as the PAC.

The Customer Service Department records updates to beneficiaries' cultural and linguistic capabilities and preferences, including standing requests for material in alternate languages and formats. Beneficiaries are informed they have access to free oral interpretation in their language and written materials translated into SCFHP's threshold languages or provided in alternative formats. Written materials translation is available in non-threshold languages upon request.

Marketing and Communications is also responsible for supporting SCFHP's CAC in accordance with Title 22, CCR, Section 53876 (c). The purpose of the CAC is to provide a link between SCFHP and the community. Meetings are chaired by designated SCFHP staff and composed of SCFHP beneficiaries and community advocates. The CAC advises SCFHP on the development and implementation of its cultural and linguistic accessibility standards and procedures. Committee responsibilities include advising on cultural competency, educational and operational issues affecting beneficiaries, including seniors, persons with LEP and disabilities. CAC reports directly to the SCFHP Governing Board.

Quality Improvement is responsible for supporting SCFHP's CAB in accordance with the DHCS Coordinated Care Initiative (CCI). The purpose of CAB is to provide a link between SCFHP and the Cal MediConnect population. Meetings are chaired by designated SCFHP staff and composed of SCFHP beneficiaries and community advocates. Committee responsibilities include advising on cultural competency, educational and operational issues affecting beneficiaries, including seniors, persons with LEP and disabilities. CAB is a subcommittee of the QIC.

Health Services (including Case Management, Managed Long Term Support Services, Behavioral Health, Utilization Management, Quality Improvement and Pharmacy) is responsible for ensuring cultural competent care coordination for all beneficiaries.

V. PROGRAM SCOPE

The C&L Services Program is comprehensive, systematic and ongoing. It includes assessment, monitoring and enhancement of all services provided directly by SCFHP, as well as all services provided by contracted providers, including pharmacies and ancillary services.

Assessment of Beneficiary Cultural and Linguistic Needs

SCFHP regularly assesses beneficiary cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. Specifically, SCFHP:

- Documents in the Health Plan's Information System the reported ethnicity and preferred language of eligible beneficiaries provided by DHCS/CMS for Medi-Cal or Cal Mediconnect beneficiaries and the internal application process for Healthy Kids beneficiaries in the uploads of beneficiary data.
- Documents beneficiary requests to change their reported ethnicity or preferred language.
- Documents a beneficiary's standing request for materials in another language or in an alternate format in the Health Plan's Information Systems.
- Instructs providers to offer no cost interpreter services and document the beneficiary's preferred language in addition to requests for, and refusals of, interpreter services in the patient chart.
- Tracks and analyzes utilization of telephone and face-to-face interpreter services at all points of contact.
- Conducts a Cultural & Linguistic and Health Education GNA every three (3) years or as often as required by DMHC or DHCS to identify C&L needs, and periodically update the assessment based on additional beneficiary input through beneficiary surveys, focus groups and grievances.
- Elicits and documents input from the CAC regarding beneficiaries' C&L needs (for details see Consumer Advisory Committee Charter).
- Elicits and documents input from the CAB regarding beneficiaries' C&L needs (for details see Consumer Advisory Board Charter).
- SCFHP makes reasonable changes to policies, procedures, and practices to provide equal access for individuals with disabilities.

Assessment of linguistic capabilities of SCFHP employees, providers, and subcontractors

SCFHP continuously assesses the linguistic capabilities of its employees, providers and subcontractors to reduce language barriers increase the quality of care LEP beneficiaries receive, and ensure the plan's ability to meet beneficiaries' ethnic, cultural and linguistic needs. SCFHP makes every effort to ensure that providers are assigned with the ability to meet beneficiaries' C&L needs. Activities that contribute to the assessment process include:

- Employees
  - Hire staff that demonstrates appropriate bilingual proficiency as needed for their role by passing a language professional test at time of hire.
  - Maintain Human Resource records on staff linguistic skills and relevant training, certification and/or proficiency results.
  - Assess the performance of employees who provide linguistic services.
- Providers
  - PCP and Specialists are required to ensure access to care for LEP speaking beneficiaries through the provider's own multilingual staff or through cultural and linguistic services facilitated by SCFHP.
  - Identify language proficiency of bilingual providers and office staff through documentation of certification of proficiency or self-assessment.
  - Report provider and office staff language capabilities for inclusion in the Provider Directory.
- Subcontractors
  - Execute agreements with subcontractors that are in compliance with the business requirements for all lines of business.
  - Execute agreements with contracted translators and interpreters that require staff to be tested for proficiency and experience.
- Maintain records in the Health Education Program of community health resources throughout the counties we serve, including the language in which the programs are offered.

Access to Interpreter Services and Availability of Translated Materials

Linguistic services are provided by SCFHP to non-English speaking or LEP beneficiaries for population groups. Services include, but are not limited to, the following:

- No cost linguistic services are provided to beneficiaries accurately and timely and protect the privacy and independence of the individual with LEP.
  - Oral interpreters, signers or bilingual providers and provider staff at all key points of contact are available in languages spoken by beneficiaries. Linguistic services are provided in all languages spoken by beneficiaries,

not just the threshold or concentration standards languages. Key points of contact include:

- Medical care settings
- Telephone, Nurse Advice Line, urgent care transactions, and outpatient encounters with healthcare providers, including: pharmacists.
- Non-medical care settings: Customer Services, orientations, and appointment scheduling.

- Written informational materials are fully translated into all threshold languages within 90 days after the English version is approved by the state. Materials in non-threshold languages are made available upon request within 30 days of the request. (Refer to Policy QI.08.02 for more information on translation into non-threshold languages) Materials include:
  - Evidence of Coverage Booklet and/or Beneficiary Handbook and Disclosure Forms. The contents of these documents includes:
    - Enrollment and disenrollment information
    - Information regarding the use of health plan services, including access to screening and triage, after-hours emergency, and urgent care services
    - Access and availability of linguistic services
    - Primary care provider (PCP) selection, auto-assignment, and instructions for transferring to a different PCP
    - Process for accessing covered services requiring prior authorizations
    - Process for filing grievances and fair hearing requests
  - Provider listings or directories
  - Formulary/Prescription Drug List
  - Marketing materials
  - Form letters (i.e. authorization notice of action letters, grievance and appeals, including resolution letters)
  - Plan-generated preventive health reminders (i.e. appointments and immunization reminders, initial health examination notices, and prenatal care follow-up)
  - Beneficiary surveys
  - Newsletters
- California Relay Services for hearing impaired.

SCFHP ensures access to interpreter services for all LEP beneficiaries. SCFHP provides 24-hour access to telephonic interpreter services for all medical and non-medical points of contact. SCFHP beneficiaries can, with advance notice, utilize in-person language and sign language interpreter services. All interpreter services are provided at no charge to beneficiaries. SCFHP requires, through contractual agreement, that contracted interpreters are tested for proficiency and experience. (For more detail please refer to Procedure QI.08.02 Language Assistance Program). SCFHP ensures access to interpreter services for all LEP and sensory impaired beneficiaries through several mechanisms:

- Inform new enrollees of available linguistic services in welcome packets.
- Provide a Interpreter Reference Guide to providers about accessing SCFHP's interpreter services.
- Provide an interpreter for scheduled appointments when requested by the provider or beneficiary.
- Ensure beneficiaries can use face-to-face language and sign language interpreters with advance notice.
- Make 24-hour/7 days a week access to telephonic interpreter services available for all medical and non-medical points of contact as defined in the contract or regulations.
- Monitor the interpreter request process to avoid unreasonable or unnecessary delays when the service is requested by the beneficiary or provider.
- Encourage the use of qualified interpreters rather than family beneficiaries or friends. The beneficiary may choose an alternative interpreter at his/her cost after being informed of the no cost service.
- Discouraging the use of minors as interpreters except in extraordinary circumstances.
- Maintain records in the Marketing and Communications Department of translated beneficiary informational materials. SCFHP translates beneficiary informing materials into all threshold languages identified by the Department of Health Care Services (DHCS). Translation into non-threshold languages is available upon request. Alternate formats, such as braille, large print, and audio are available upon request.
- Ensure beneficiaries are made aware they have the right to file a complaint or grievance if their linguistic needs are not met.

SCFHP complies with the non-discrimination requirement set forth under Section 1557 of the Affordable Care Act (ACA). SCFHP does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (APL 17-011). This includes:

- Posting of the Notice of Non-Discrimination, including Non-Discrimination Statements, in all beneficiary communications and publications, including written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits.
- Posting the Notice on-site at SCFHP and on the SCFHP website in a conspicuous location and conspicuously visible font size.
- Posting taglines in a conspicuously visible font size in English and at least the top 16 non-English languages spoken by individuals with LEP in California. These taglines inform individuals with LEP of the availability of language assistance services in all beneficiary communications and publications.
    - Languages include: Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Punjabi, Russian, Spanish, Tagalog, Thai, and Vietnamese.

Staff and Provider Cultural Competency and Diversity Training

SCFHP provides cultural competency, sensitivity, or diversity training for staff, Network Providers, and First Tier, Downstream and Related Entities with direct beneficiary interaction. SCFHP conducts annual cultural competency trainings for SCFHP employees. Network providers receive C&L training as part of Provider Orientation. SCFHP also provides regular training and information sessions to ensure employees and providers are informed and aware of SCFHP's policies and procedures regarding the provision of CLAS. Training includes DHCS-developed cultural awareness and sensitivity instruction for Seniors and Persons with Disabilities or chronic conditions. (DHCS Medi-Cal Contract, Exhibit A, Attachment 7, 5.B). Training on culturally and linguistically appropriate care and care coordination is made available to SCFHP staff. Specifically, SCFHP offers:

- Department-specific periodic trainings on C&L issues on topics such as health literacy, utilization of interpreter services, identifying and handling C&L grievances, customer service to a diverse membership, etc.
- New provider orientations that cover the Culturally Competency Toolkit and SCFHP C&L policies and procedures, specifically addressing provider responsibilities for providing CLAS and utilization of interpreter services.
- One-on-one provider and provider office staff training on C&L issues when a need is identified to improve provider effectiveness in meeting beneficiaries' C&L needs.
- Training, educational materials and tools regarding various cultures and CLAS are made available to SCFHP staff and network providers.

Monitoring, Evaluation and Enforcement

To ensure that SCFHP employees and providers adhere to its C&L services policies and procedures, and that these policies and procedures result in services that are effective in providing CLAS, SCFHP conducts regular monitoring and enforcement activities regarding staff, provider, and interpreter performance that include, but are not limited to:

- Consumer/beneficiary satisfaction surveys

- Review of beneficiary grievances
- Provider assessments and provider site reviews
- Provider satisfaction surveys
- Feedback on services from CAC, CAB, the Provider Advisory Council and Provider Office Staff Committee, QIC, SCFHP staff and network providers, community-based organization partners, and other focus group reports
- Audits of delegated provider groups
- Data from utilization reports
- Analysis of health outcomes

Health disparities and utilization patterns by race, ethnicity, and language are investigated by SCFHP's Quality Improvement Department and appropriate interventions are implemented as needed.

APPENDIX A

Santa Clara Family Health Plan- Cultural and Linguistic Oversight and Staff:

Christine Tomcala, Chief Executive Officer

Laurie Nakahira, DO, Chief Medical Officer

Chris Turner, Chief Operating Officer

Johanna Liu, Pharmacy and Quality Director

Robin Larmer, Chief Compliance and Regulatory Affairs Officer

Laura Watkins, Director of Marketing, Outreach, and Enrollment

Eric Tatum, Director of Provider Network Management

Tanya Nguyen, Director of Customer Service

Mai Chang, Quality Improvement Manager

Jamie Enke, Process Improvement Manager

Mansur Zahir, Process Improvement Project Manager

Mariana Ulloa, Quality Improvement Project Manager

Divya Shah, Health Educator

Cecilia Le, Quality Improvement Coordinator

Zara Hernandez, Quality Improvement Coordinator

Patricia Smith, Quality Improvement Nurse

The Quality Department staff is responsible for developing, implementing and evaluating SCFHP's Cultural and Linguistic Services in coordination with Provider Network Management, Customer Service, Compliance, and Health Services Departments. The Quality Improvement Coordinators, Health Educator and Quality Improvement Nurse report to the Quality Improvement Manager. The Quality Improvement Manager reports to the Pharmacy and Quality Director, who in turn reports to the Chief Medical Officer. The Chief Medical Officer reports to

the Chief Executive Officer. The Compliance Officer, Director of Marketing, Communications and Outreach, Director of Provider Network Management and the Director of Customer Service report to the Chief Operations Officer.

The Director of Marketing, Communications and Outreach has oversight of the Consumer Advisory Committee.

The Director of Pharmacy and Quality has oversight of the Consumer Advisory Board.

CULTURAL AND LINGUISTICS WORK PLAN 2019

Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion	Completed
Comply with state and federal guidelines related to caring for limited English proficient (LEP) and sensory impaired members	Pg. 61, Exhibit A, Attachment 9 13.C.3 DHCS APL 17-002	GNA Update for DHCS	- See QI Work Plan for projects focusing on priorities areas	Health Educator, QI Dept.	Ongoing	Annually	
	DMHC TAG - Language Assistance Program 28 CCR 1300.67.04(c)	Language assistance program Policy and Procedures (Title 28, Sec. 1300.67.04) has standards for: 1) enrollee assessment, 2) providing language assisstance services, 3) staff training, 4) Compliance monitoring	Policy and Procedures	Health Educator, QI Dept.	Ongoing	Continuous	
Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	2.9.7.4.	Distribute "Quick Guide" for accessing interpreter services to all providers	Interpreter Reference Guide for Providers	Health Educator, PNM, Delegation Oversight	Ongoing	Continuous	
	Exhibit A, Attachment 9 9.14.b (p. 63)	Promote interpreter services at no charge to members and providers	EOC, Language Assistance Services document included in member mailings, SCFHP Website	QI, Marketing, Customer Service	Ongoing	Continuous	
	Exhibit A, Attachment 9 15	Use the CAC for advice and feedback on CLAS and procedures	CAC Agenda	QI, Marketing	Ongoing	Continuous	
	Exhibit A, Attachment 14.3.B.2	Use available C&L member reports, e.g. grievances and appeals, to identify interventions to improve quality	Reports from G&A, Language vendor utilization reports	Health Educator, QI, Grievance and Appeals	Quarterly	Continuous	
	2.9.7.4.	Include C&L as agenda item at Joint Operation Committee meetings with delegates as appropriate	JOC Agenda	Health Educator, QI, Delegation Oversight	Ongoing	Continuous	
		Include C&L Compliance, including training, in all Delegation Oversight Audits	Audit tools	Health Educator, QI, Delegation Oversight	Ongoing	Annually	
	Exhibit A, Attachment 9,13.E	Include C&L Training in new provider and sub-contactor orientations. Training content shall include: language access requirements, tips for working with interpreters, cross-cultural communications, strategies to address health literacy, health beliefs, strategies for working with LEP members and SPDs, and disability sensitivity.	Provider Training Slides	Health Educator, QI, PNM	Ongoing	Continuous	

	Exhibit A, Attachment 9,13.E	Provide ongoing training for all SCFHP staff members	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Continuous	
Promote a culturally competent health care and work environement for the SCFHP	Exhibit A, Attachment 9,13.E	New employees complete an online training when hired	Log of new staff who completed C&L Trainings	Health Educator, QI, HR	Ongoing	Continuous	
	28 CCR 1300.67.04(d)(9)	Bilingual staff completed language proficiency test	Log of staff that complete language proficiency test	Health Educator, QI, HR	Ongoing	Continuous	
	Exhibit A, Attachment 9,13.E	Review All Staff C&L Training Slides	C&L staff training slides	Health Educator, QI	Ongoing	Annually	
	Exhibit A, Attachment 9,13.E	Send All Staff Quarterly e-mail about various C&L topics	Copies of e-mails	Health Educator, QI	Ongoing	Quarterly	
	Exhibit A, Attachment 9,13.E	Implement All Staff Cultural Competency Training	Staff attestations	Health Educator, QI	Ongoing	Annually	
Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	Exhibit A, Attachment 9.13.A.1	Participate in CLAS focused plan, community, state/federal organizations, partnerships, and projects	Participation in quarterly HECLW and ICE Collaborative calls	Health Educator, QI	Ongoing	Continuous	
	Exhibit A, Attachment 9.13.A.1	Use a strategy of interdepartmental collaboration to identify and promote CLAS best practices in all areas		Health Educator, QI	Ongoing	Continuous	
Use outcome, process and strucutre measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9.13.A.1	Design oversight mechanisms that monitor for CLAS and cultural competency		Health Educator, QI	Ongoing	Continuous	
	Exhibit A, Attachment 9.13.A.5	Monitor interpreter issues identifed by internal staff, e.g. no-show interpreters	Log of identified interpreter issues	Health Educator, QI	Ongoing	Continuous	
	2.17.5.9.4.	Train all member-facing departments on updated QNXT process for logging alternate language and format (braille, audio, large print) requests	Training Slides, Sign-in sheets	Health Educator, QI	Ongoing	Continuous	
	2.17.5.9.4.	Monitor QNXT process for logging alternate language and format request monthly for 3 months	IT report	Health Educator, QI	Ongoing	Monthly	
	2.17.5.9.4.	Work with IT to update QNXT alternate language and format report	IT report	Health Educator, QI, IT	Ongoing	Apr-19	
	Exhibit A, Attachment 6 13	Develop quarterly report for Provider Network Management to analyze languages spoken by contracted providers	Interpreter utilization log with provider data	Health Educator, QI, PNM	Ongoing	Quarterly	
	Exhibit A, Attachment 9,13.F	Develop monthly interpreter service reports to ensure compliance with regulatory requirements and for tracking and trending purposes	Interpreter utilization log	Health Educator, QI	Ongoing	Monthly	
	Exhibit A, Attachment 9,13.F	Maintain log of all materials translaton request	Translation services log	Health Educator, QI	Ongoing	Continuous	

CULTURAL AND LINGUISTICS EVALUATION 2018

Project Objectives	Contract Reference	Activity	Final Deliverables	Responsible Position	Reporting Frequency	Target Completion	Completed
Comply with state and federal guidelines related to caring for limited English proficient (LEP) and sensory impaired members	Pg. 61, Exhibit A, Attachment 9 13.C.3 DHCS APL 17-002	GNA Update for DHCS	- See QI Work Plan for projects focusing on priorities areas	Health Educator, QI	Ongoing	Annually	Included in QI Work Plan
		Submit DHCS one copy of materials provided to new members for each threshold language	Copy of materials submitted to DHCS	Health Educator, QI	Ongoing	Continuous	Ongoing
	DMHC TAG - Language Assistance Program 28 CCR 1300.67.04(c)	Language assistance program Policy and Procedures (Title 28, Sec. 1300.67.04) has standards for: 1) enrollee assessment, 2) providing language assisstance services, 3) staff training, 4) Compliance monitoring	Policy and Procedures	Health Educator, QI	Ongoing	Continuous	Policies updated Q1 2018
Improve the quality of health care services for all SCFHP members at medical and non-medical points of contact	2.9.7.4.	Distribute "Quick Guide" for accessing interpreter services to all providers	Interpreter Reference Guide for Providers	Health Educator, PNM, Delegation Oversight	Ongoing	Continuous	Aug-18
	Exhibit A, Attachment 9 9.14.b (p. 63)	Promote interpreter services at no charge to members and providers	EOC, Language Assistance Services document included in member mailings, SCFHP Website	QI, Marketing, Customer Service	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 9 15	Use the CAC for advice and feedback on CLAS and procedures	CAC Agenda	QI, Marketing	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 14.3.B.2	Use available C&L member reports, e.g. grievances and appeals, to identify interventions to improve quality	Reports from G&A, Language vendor utilization reports	Health Educator, QI, Grievance and Appeals	Quarterly	Continuous	Ongoing
	2.9.7.4.	Include C&L as agenda item at Joint Operation Committee meetings with delegates as appropriate	JOC Agenda	Health Educator, QI, Delegation Oversight	Ongoing	Continuous	Q4 2018
	Exhibit A, Attachment 9.13.A.4	Include C&L Compliance, including training, in all Delegation Oversight Audits	Audit Tool	Health Educator, QI, Delegation Oversight	Ongoing	Annually	Ongoing
	Exhibit A, Attachment 9,13.E	Include C&L Training in new provider and sub-contactor orientations	Provider Training Slides	Health Educator, QI, PNM	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 9,13.E	Include resources in training related to gender, sexual orientation or gender identity	C&L All Staff Training Slides	Health Educator, QI	Once	Q4 2018	Q4 2018
	Exhibit A, Attachment 9,13.E	Provide ongoing training for all SCFHP staff members	Training Slides, Sign-in Sheets	Health Educator, QI	Ongoing	Continuous	June 2018 December 2018

Promote a culturally competent health care and work environement for the SCFHP	Exhibit A, Attachment 9,13.E	New employees complete an online training when hired	Log of new staff who completed C&L Trainings	Health Educator, QI, HR	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 9,13.E	Culturally relevant materials and event notices made available to employees	Copies of materials provided to employees	Health Educator, QI, Marketing	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 9,13.E	Review and revise staff training module to incorporate information related to disabilities, and regardless of gender, sexual orientation or gender identity	C&L Training Slides	Health Educator, QI	Once	Q4 2018	Q4 2018
Promote CLAS "best practices" for implementation by SCFHP, as well as network providers and subcontractors.	Exhibit A, Attachment 9.13.A.1	Participate in CLAS focused plan, community, state/federal organizations, partnerships, and projects	Participation in quarterly HECLW and ICE Collaborative calls	Health Educator, QI	Ongoing	Continuous	Participation in HECLW meetings and ICE Calls in 2018
	Exhibit A, Attachment 9.13.A.1	Use a strategy of interdepartmental collaboration to identify and promote CLAS best practices in all areas	Training materials provided to departments	Health Educator, QI	Ongoing	Continuous	Worked with IT to implement QNXT alternate language feature - Q4 2018 Language assistance training provided to member-facing departments - Q2 2018
Use outcome, process and structure measures to monitor and continuously improve SCFHP's activities aimed at achieving cultural competence and reducing health care disparities	Exhibit A, Attachment 9.13.A.1	Design oversight mechanisms that monitor for CLAS and cultural competency	Completed C&L Audit tools	Health Educator, QI	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 9.13.A.1	Use the delegated audit process to identify subcontractor compliance with CLAS; work with providers to improve compliance	Completed C&L Audit tools	Health Educator, QI	Ongoing	Continuous	All C&L audits completed in 2018
	Exhibit A, Attachment 14.3.B.2	Monitor greivance and appeals to identify areas of improvement and forward data to appropriate department(s)	Log if G&A issues	Health Educator, QI	Ongoing	Continuous	Ongoing
	Exhibit A, Attachment 14.3.B.2	Monitor interpreter issues identifed by internal staff, e.g. no-show interpreters	Log of interpreter issues	Health Educator, QI	Onging	Continuous	Ongoing
	2.17.5.9.4.	Work with IT to implement QNXT process for logging standing alternate language and format (braille, audio, large print) requests	QNXT attribute updates	Health Educator, QI, IT	Once	Dec-18	Dec-18

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Potential Quality of Care Issue (PQI)**	**Policy No.:**	QI.05
Replaces Policy Title (if applicable):	Potential Quality of Care Issues	**Replaces Policy No. (if applicable):**	QM002_02
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define Santa Clara Family Health Plan's policy to identify, address and respond to Potential Quality of Care Issues (PQI).

II. Policy

Santa Clara Family Health Plan (SCFHP) monitors, evaluates, and takes actions to support the quality of care and services delivered to members. The plan identifies and addresses PQI's in order to address potential safety concerns and improve member outcomes.

Potential Quality of Care issues are considered for all providers and provider types such as individual practitioners, groups and facilities. All service types, such as preventive care, primary care, specialty care, emergency care, transportation and ancillary services are considered and are subject to disciplinary action. Availability of care, including case management for the SPD population, continuity of care and coordination of care are also considered. The Plan monitors and analyzes data to determine if services meet professionally recognized standards of practice. Any grievance or PQI referral that involves quality of care or potential adverse outcome to a member is referred to a Medical Director.

III. Responsibilities

PQIs may initially be identified by multiple departments within the plan: Health Services, Customer Service, Appeals and Grievances, Credentialing, Provider Services, Compliance, IT, QI, or Claims. All areas are responsible for reporting PQIs to the QI department.

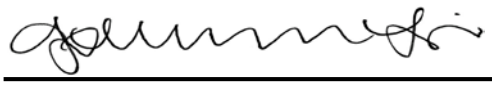
IV. References

California Code and Regulations:

1. 28 CCR 1300.68(a)(e)
2. 28 CCR 1300.70(b)(2)(I)(2)
3. 28 CCR 1300.70(a)(1)
4. 28 CCR 1300.70(b)(2)(C) through (E)

California Health and Safety Code section 1367.1

V. Approval/Revision History

First Level Approval	Second Level Approval
	
Signature Johanna Liu, PharmD	Signature Jeff Robertson, MD
Name Director of Quality and Pharmacy	Name Chief Medical Officer
Title 06/06/2018	Title 06/06/2018
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve 5/10/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve 05/10/2017**	
V1	**Reviewed**	**Quality Improvement**	**Approve 06/06/2018**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Physical Access Compliance**	**Policy No.:**	QI.07
Replaces Policy Title (if applicable):	Physical Access Compliance Policy	**Replaces Policy No. (if applicable):**	QM107
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To define the process Santa Clara Family Health Plan (SCFHP) follows to monitor that ADA requirements are assessed and compliance is maintained at practice sites for Primary Care Practices, high volume specialists, Community-Bases Adult Services (CBAS) and ancillary practices.

II. Policy

Santa Clara Family Health Plan (SCFHP) conducts a physical accessibility review at every contracted Primary Care Physician (PCP) office, defined high volume specialist, Community-Based Adult Services (CBAS) and ancillary practice site listed in the Plan's provider directory.

To drive corrective actions when needed, and monitor the results of the physical assessment review which are made available to SCFHP members following the Department of Healthcare Services (DHCS) requirements.

III. Responsibilities

SCFHP Quality Improvement Department (QI) performs site reviews and reports to the Quality Improvement Committee. Complaints regarding related office accessibility issues are reported by QI to PR/Credentialing as appropriate. Customer Service/IT reports track/trend provider access complaints.

IV. References

Access to Medical Care for Individuals with Mobility Disabilities, July 2010, U.S. Department of Justice, Civil Rights Division, Disability Rights Section

DPL14-005 – Facility Site Reviews/Physical Accessibility Reviews
APL15-023 – Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers

PL 12-006 - Revised Facility Site Review Tool

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are 1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California, Department of General Services, Division of the State Architect. Updated April 27, 2010
DHCS/SCFHP Contract:
Exhibit A, Attachment 4 - QUALITY IMPROVEMENT SYSTEM

4. Quality Improvement Committee

8. Quality Improvement Annual Report

10. Site Review

Exhibit A, Attachment 7 - PROVIDER RELATIONS

5. Provider Training

Exhibit A, Attachment 9 - ACCESS AND AVAILABILITY

11. Access for Disabled Members

V. Approval/Revision History

First Level Approval	Second Level Approval
Signature Johanna Liu, PharmD Name Director of Quality and Pharmacy Title 06/06/2018 Date	Signature Jeff Robertson, MD Name Chief Medical Officer Title 06/06/2018 Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement**	**Approve:11/9/2016**	
V1	**Reviewed**	**Quality Improvement**	**Approve: 5/10/2017**	
V1	**Reviewed**	**Quality Improvement**	**Approve: 06/06/2018**	

Santa Clara Family Health Plan

POLICY

Policy Title:	Initial Health Assessments (IHA) and Staying Healthy Assessment (SHA)	**Policy No.:**	QI.10
Replaces Policy Title (if applicable):	Initial Health Assessments (IHA's) and Individual Health Education Behavior Assessment (IHEBA) Initial Health Assessments (IHA's) and Behavioral Assessment (HEBA)	**Replaces Policy No. (if applicable):**	HE004_05
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	☒ Medi-Cal ☐ Healthy Kids		☐ CMC

I. Purpose

1. The purpose of this policy is to describe the required completion of the Initial Health Assessments (IHA) and the Staying Healthy Assessment (SHA) by contracted providers.
2. To define the process that Santa Clara Family Health Plan (SCFHP) will oversee the completion of IHAs and SHAs.

II. Policy

1. It is the policy of SCFHP to support the contracted network in the use and administration of the SHA to all Medi-Cal members as part of the IHA and to periodically re-administer the SHA according to contract requirements in a timely manner.
2. It is the policy of SCFHP to meet the Department of Health Care Services contractual requirements for an IHA and a SHA to be performed within 120 days of a member's enrollment in SCFHP and that the subsequent SHA is re-administered at appropriate age intervals.

III. Responsibilities

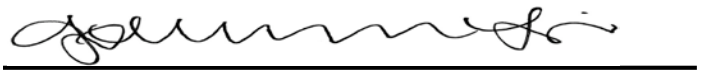
The Quality Improvement Department is responsible for monitoring compliance of the policy and to collaborate with the Health Education and Provider Services department to train/educate providers on IHA/SHA requirements.

IV. References

MMCD Policy Letter 13-001, DHCS Contract Exhibit A Attachment 10, Provisions 3, 4, 5 A and B, and 6.
MMCD Policy Letter 08-003: Initial Comprehensive Health Assessment
Staying Healthy Assessment Questionnaires and Counseling and Resource Guide
American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
Web site for SHA Questionnaires and Resources
http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

Santa Clara Family Health Plan™

V. Approval/Revision History

First Level Approval	Second Level Approval
POLICY	
	
Signature	Signature
Johanna Liu, PharmD	Jeff Robertson, MD
Name	Name
Director of Quality and Pharmacy	Chief Medical Officer
Title	Title
05/15/2017	05/15/2017
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
v1	**Original**	**Quality Improvement Committee**	**Approve; 08/10/2016**	
V1	**Reviewed**	**Quality Improvement Committee**	**Approve: 05/10/2017**	

POLICY

Santa Clara
Family Health Plan

Policy Title:	**Health Homes Program**	**Policy No.:**	QI.28
Replaces Policy Title (if applicable):		**Replaces Policy No. (if applicable):**	
Issuing Department:	Quality Improvement	**Policy Review Frequency:**	Annually
Lines of Business (check all that apply):	× Medi-Cal	□ Healthy Kids	□ CMC

I. Purpose

The Health Homes Program (HHP) offers coordinated care to individuals with multiple chronic health conditions, including mental health, substance use disorders and those experiencing homelessness. The HHP is a team-based clinical approach that includes the member, their providers, and family members (when appropriate). The HHP builds linkages to community supports and resources, as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medi-Cal HHP offers comprehensive, high quality health care for eligible Santa Clara Family Health (SCFHP) Plan Medi-Cal members. The purpose of this policy is to identify all of the HHP requirements for SCFHP and selected Community-Based Care Management Entities (CB-CMEs). SCFHP will work with selected CB-CMEs to facilitate care planning, care coordination, care transitions, and housing navigation services. SCFHP will utilize communication and reporting capabilities to perform health promotion, encounter reporting, and quality of care reporting. Selected CB-CMEs will serve as the community-based entity with responsibilities that will ensure members receive access to HHP services.

II. Policy

SCFHP will be responsible for the overall administration of the HHP. SCFHP will have oversight of the CB-CMEs and their performance. CB-CMEs will provide all members with access to the same level of HHP service, in accordance with the tier/risk grouping that is appropriate for members' needs and HHP service requirements. SCFHP will perform regular auditing and monitoring activities to ensure that all HHP services are delivered according to the contract signed by the selected CB-CMEs and SCFHP. SCFHP will select and assess the readiness of community organizations to serve as CB-CMEs. Selected entities will need to provide all core services of the HHP, including:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Supports
- Housing Navigation

I. SCFHP Responsibilities:

a. Maintain the HHP infrastructure with contracted CB-CMEs and ensure that the roles and division of responsibility between the CB-CME and SCFHP are clearly identified
    i. SCFHP will utilize Model I
        1. All qualified members will be served by Model I

a. Model II will only be used if delegation occurs

2. SCFHP will partially use delegation
    a. Delegation will occur if the delegated health plan can implement Health Homes Model I and/ or Model II
    b. Model II should only be used if the delegated plan provides adequate reason to why care management services cannot be held at the CB-CME
3. Selected CB-CMEs will either be a care management entity or a clinic based facility with care management services
4. The same care management system will be used among all CB-CMEs and delegated health plans to ensure reporting and information sharing can be completed on a timely basis Ensure that the CB-CME has the capacity to provide assigned HHP members with a multi-disciplinary care team

b. SCFHP will provide outreach to provider networks and hospital systems to strengthen multi-disciplinary participation from non-participating CB-CMEs
    1. Site visits, marketing materials, and ongoing informational webinars will be utilize to disseminate information
c. Share information with CB-CMEs to assist with identifying patients and providing HHP services; data sharing agreements will be established with selected CB-CMEs and SCFHP:
    i. SCFHP will notify CB-CME of inpatient admissions and ED visits/discharges
    ii. SCFHP will share each member's health history with assigned CB-CMEs
    iii. Data will be exchanged between CB-CME and SCFHP to better track CMS-required quality measures and state-specific measures, including health status and outcomes data for the DHCS evaluation process
d. Identify, review and prioritize HHP eligible members by tier/risk grouping and assign members to CB-CMEs
    i. Identify members through the DHCS-provided Targeted Engagement List (TEL), internal TEL, and member/provider referrals
    ii. Group members according to a tier structure, which should correlate with the member's risk grouping and intensity of services needed
e. Reduce the duplication of services to the member by verifying eligible members' involvement in other case management programs (e.g., Whole Person Care)
f. Develop CB-CME training tools as needed, as well as coordinate trainings to strengthen skills for CB-CMEs in conjunction with HHP
g. Develop and administer payment structure for CB-CMEs
    i. Payment structure may consider the payments received from DHCS, member's tier/risk grouping and any other supplemental funding
h. Prepare SCFHP's Customer Service, Nurse Advice Line, and other staff as necessary to ensure HHP members' needs can be addressed

II. **CB-CME Responsibilities**

a. CB-CMEs retain overall responsibility for all duties that the CB-CME has agreed to perform for SCFHP, as defined in the contract between the CB-CME and SCFHP
    i. CB-CME will perform all seven core services to the HHP-eligible member, as defined in the DHCS HHP Program Guide
b. Complete a readiness assessment as developed by SCFHP
    i. If services are insufficient, CB-CME will work with SCFHP to fulfill the readiness gaps prior to enrolling members
c. Ensure that providers with experience servicing frequent utilizers of health services and those experiencing homelessness, are available as needed per AB 361 requirements
d. Leverage existing county and community provider care management infrastructure and experience, where possible and appropriate

e. Ensure assigned HHP members receive access to HHP services including completing a patient-centered health action plan (HAP) within 90 days of enrollment
    i. Maintain a strong and direct connection to the PCP and ensure PCP's participation in HAP development and ongoing coordination
    ii. Assess the HHP member's physical, behavioral, substance use, palliative, trauma-informed care, and social services need using screenings and assessments with standardized tools
f. Maintain a multi-disciplinary care team to provide outreach and enrollment
    i. CB-CME will utilize assigned member lists provided by SCFHP to complete outreach and enrollment
    ii. Ensure needs are met based on the member's HAP and the tiered structure outlined by SCFHP
g. Utilize existing health information technology (HIT) to collect and share data to SCFHP
    i. If CB-CME does not have adequate technology, CB-CME will work with SCFHP to determine how information will be shared for HHP services and reporting purposes
h. CB-CME will attend required trainings for the HHP
i. CB-CME may utilize community health workers to conduct outreach and other services as appropriate

I. References

- Department of Health Care Services. (2018). *Medi-Cal Health Homes Program-Program Guide.* Sacramento, CA
- Department of Health Care Services. (2018). *All Plan Letter 18-012.* Sacramento, CA: Managed Care Quality and Monitoring Division.
- Legislative Counsel's Digest. (2013). *AB-361 Medi-Cal: Health Homes for Medi-Cal Enrollees and Section 1115 Waiver Demonstration Population with Chronic and Complex Conditions.* Sacramento, CA: Marjorie Swartz.

II. Approval/Revision History

First Level Approval	Second Level Approval
Signature	Signature
Name	Name
Title	Title
Date	Date

Version Number	Change (Original/ Reviewed/ Revised)	Reviewing Committee (if applicable)	Committee Action/Date (Recommend or Approve)	Board Action/Date (Approve or Ratify)
Insert Version # of policy	Indicate if this is an original, reviewed or revised policy	Name of the Committee reviewing prior to going to Board	Indicate whether the committee approved or is recommending approval & Date	Indicate Approve or Ratify & Date

Santa Clara Family Health Plan

SCFHP Americans with Disabilities Act Workplan

SCFHP maintains a robust Americans with Disabilities Act (ADA) Workplan. The plan is comprised of different metrics measuring patient safety, access, health education, grievance monitoring, and delivery of preventive care

Domain	Measure	Reporting Frequency	Target Compleion	Completed	Findings
Workplan	ADA Workplan is reviewed and evaluated on an annual basis	Annual	February 2019		
Responsible Party	Identify responsible individual for ADA Compliance	Annual	February 2019	February 2019	Director of Quality and Pharmacy has oversight for ADA Compliance.
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: CBAS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: LTSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: Nursing Home	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of Critical Incidents reported in an MLTSS Setting: IHSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Potential* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		

Domain	Measure	Reporting Frequency	Target Compleion	Completed	Findings
Patient Safety	Number of *Potential* Quality of Care Issues identified at: IHSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: LTSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Potential* Quality of Care Issues identified at: Nursing Home	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: CBAS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: LTSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: Nursing Home	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Number of *Validated* Quality of Care Issues identified by: IHSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Access	PAR Site Identification: Plan refreshes claims history to identify new high volume specialists and ancillary providers for review	Annual	January 31, 2019	January 31, 2019	
Access	Physical Accessibility Review: Number of LTSS sites reviewed	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		

Domain	Measure	Reporting Frequency	Target Compleion	Completed	Findings
Access	Physical Accessibility Review: Number of CBAS sites reviewed	Quarterly (only required once every three years)			
Access	Number of referrals to: CBAS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Access	Number of referrals to: MSSP	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Access	Number of referrals to: Nursing Home	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Access	Number of referrals to: IHSS	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Access	Physical Accessibility Review: Number of High Volume Specialists	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Access	Physical Accessibility Review: Number of Ancillary sites reviewed	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Preventive Care	HEDIS: Care of Older Adults - Functional Status Assessment	Annual	June 2019		
Preventive Care	Medication Reconciliation Post-Discharge	Annual	June 2019		
Group Needs Assessment - Full	Group Needs Assessment Report shared at: Consumer Advisory Committee Quality Improvement Committee	Every Five Years			

Domain	Measure	Reporting Frequency	Target Compleion	Completed	Findings
Group Needs Assessment - Annual Update	Group Needs Assessment Annual Update shared at: Consumer Advisory Committee Quality Improvement Committee	Annual			
Health Education	Plan monitors health education referrals for CMC members: Number of referrals from members who are also in CBAS, LTSS, IHSS or Nursing Homes	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Patient Safety	Plan monitors grievances for reasonable accommodations and access to services under ADA	Quarterly	3/31/2019 6/30/19 9/30/19 12/31/19		
Group Needs Assessment - Full	Group Needs Assessment Report will analyze results to understand underlying causes of barriers to health care access.	Every Five Years			
Workplan	Plan will identify issues within its system that require improvement to promote access and ADA compliance	Annual	December 2019		

QUALITY IMPROVEMENT
COMMITTEE or ACTIVITY REPORT

Name of Reporting Committee or Activity: Credentialing Committee

Monitoring or Meeting Period: December 12, 2018

Areas of Review or Committee Activity

Credentialing of new applicants and recredentialing of existing network practitioners

Findings and Analysis

Initial Credentialing (excludes delegated practitioners)		
Number initial practitioners credentialed	2	
Initial practitioners credentialed within 180 days of attestation signature	100%	100%
Recredentialing		
Number practitioners due to be recredentialed	29	
Number practitioners recredentialed within 36-month timeline	29	
% recredentialed timely	100%	100%
Number of Quality of Care issues requiring mid-cycle consideration	0	
Percentage of all practitioners reviewed for ongoing sanctions or licensure limitations or issues	100%	100%
Terminated/Rejected/Suspended/Denied		
Existing practitioners terminated with cause	0	
New practitioners denied for cause	0	
Number of Fair Hearings	0	
Number of B&P Code 805 filings	0	
Total number of practitioners in network (excludes delegated providers) as of 11/30/2018	265	

(For Quality of Care ONLY)	**Stanford**	**LPCH**	**NT 20**	**NT 40**	**NT 50**	**NT 60**
Total # of Suspension	0	0	0	0	0	0
Total # of Terminations	0	0	0	0	0	0
Total # of Resignations	0	0	0	0	0	0
Total # of practitioners	1462	1226	711	776	400	117

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Actions Taken

1. All current network practitioners and providers were monitored on an ongoing basis for licensing issues, sanctions, validated quality of care issues and opt-out exclusion. No currently credentialed practitioner or provider had an identified issue on any of the exclusion lists or licensing boards.
2. Staff education conducted regarding the recredentialing of practitioners within the required 36-month timeframe. Procedure review of mailing pre-populated recredentialing applications six months prior to due date reviewed.

Outcomes & Re-measurement

Weekly re-measurement will be conducted on recredentialing applications to measure compliance

Note: This is a count of single providers in their credentialed networks. A provider belonging to multiple networks will be counted for each network once.

Regular Meeting of the
Santa Clara County Health Authority d.b.a. Santa Clara Family Health Plan
CLOSED SESSION - **Pharmacy & Therapeutics Committee**
Thursday, September 20, 2018
6:00 PM - 8:00 PM
6201 San Ignacio Avenue San Jose, CA 95119

MINUTES

Voting Committee Members	Specialty	Present (Y or N)
Jimmy Lin, MD	Internal Medicine	N
Hao Bui, BS, PharmD	Community Pharmacy (Walgreens)	N
Minh Thai, MD	Family Practice	N
Amara Balakrishnan, MD	Pediatrics	Y
Peter Nguyen, MD	Family Practice	Y
Jesse Parashar-Rokicki, MD	Family Practice	Y
Narinder Singh, PharmD	Health System Pharmacy (SCVMC)	Y
Ali Alkoraishi, MD	Adult & Child Psychiatry	Y
Dolly Goel, MD	VHP Chief Medical Officer	N
Xuan Cung, PharmD	Pharmacy Supervisor (VHP)	Y
Johanna Liu, PharmD, MBA	SCFHP Director of Quality and Pharmacy	N
Jeff Robertson, MD	SCFHP Chief Medical Officer	Y

Non-Voting Committee Members	Specialty	Present (Y or N)
Lily Boris, MD	SCFHP Medical Director	N
Caroline Alexander	SCFHP Administrative Assistant, Medical Management	Y
Tami Otomo, PharmD	SCFHP Clinical Pharmacist	Y
Duyen Nguyen, PharmD	SCFHP Clinical Pharmacist	Y
Dang Huynh, PharmD	SCFHP Pharmacy Manager	Y
Amy McCarty, PharmD	MedImpact Clinical Program Manager	Y
Tiffanie Pham, CPhT	SCFHP Pharmacy Coordinator	N

	Topic and Discussion	Follow-Up Action
1	**Introductions**	
	The meeting convened at 6:15 PM.	
2	**Public Comment**	
	No public comment.	
3	**Past Meeting Minutes**	

	The SCFHP 2Q2018 P&T Minutes from June 21, 2018 were reviewed by the Committee as submitted. One minor correction on the address in Health Plan Updates section. Address should be 6201 San Ignacio Avenue, not 50 Great Oaks.	Upon motion duly made and seconded, the SCFHP 2Q2018 P&T Minutes from June 21, 2018 were approved as corrected and will be forwarded to the QI Committee and Board of Directors.
4	**Plan Updates**	
	Health Plan Updates Dr. Robertson presented the Health Plan Updates. Santa Clara Family Health Plan has moved to the new building on 6201 San Ignacio Avenue. Completed first CMS audit. Health Plan delegates to MedImpact and there were findings. Policy and procedure changes are being made to address this. Approximately 40 findings, close to national average of 36 findings.	
	Appeals & Grievances Dr. Huynh presented the Appeals & Grievances report Q3 2017 through Q2 2018. Slight decrease in Medi-Cal appeals. Downward trend. Committee requested to know what happened in March 2018. Majority were upheld (49%), 33%.	
	SCFHP Global DUR Dr. Huynh presented an update on Global DUR. Health Plan will be running reports similar to DHCS DUR team. Evaluating medications in our population.	
	Annual Charter Review Dr. Robertson presented the Pharmacy committee charter for annual review. No changes made to the charter.	
	Hepatitis C Policy Update Dr. Huynh presented an update on the Hepatitis C policy. Policy update was effective on July 1st. Main change is not looking at fibrosis score. Age requirement is 12 years and up.	
	2019 CMC Transition Fill Policy For state covered drugs, the plan will apply transition of care logic to non-Part D drugs. The logic is similar to the Part D functionality and allows new enrollees a transition fill for a defined period of time for a specific day supply limit (e.g., 31 day supply). The plan will ensure that	Upon motion duly made and seconded, 2019 CMC Transition Fill Policy was approved as presented.

	in the retail setting, the transition policy provides for up to a one-time, temporary 1 month's supply day fill(unless the enrollee presents with a prescription written for less than 31 days in which case the plan must allow multiple fills to provide up to a total of 31 days of medication). The plan will ensure that in the long-term care setting, the transition policy provides for a 1 month supply day fill consistent with the applicable dispensing increment in the long-term care setting (unless the enrollee presents with a prescription written for less), with refills provided if needed during the first 90 days of a member's enrollment in a plan, beginning on the enrollee's effective date of coverage.	
	2019 CMC Opioid Strategy Dr. Huynh presented the 2019 CMC Opioid Strategy. In alignment with CDC recommendation. Soft edit is 90 or more at point of sale at pharmacy. Hard edit requires coverage determination. Seven day supply for new start. Pharmacist may override point of sale edit on concurrent opioid and benzo or if on two long lasting opioids from 2 or more prescribers.	
	Adjourn to Closed Session Committee adjourned to closed session at 6:43 p.m. to discuss the following items: Membership Report, Pharmacy Dashboard, Drug Use Evaluation Results, Drug Utilization & Spend, Recommendations for Changes to SCFHP Cal MediConnect Formulary and Prior Authorization Criteria, Recommendations for changes to Medi-Cal and Healthy Kids Formulary and Prior Authorization Criteria, DHCS Medi-Cal CDL Updates & Comparability, Prior Authorization Criteria and New Drugs.	
5	**Metrics & Financial Updates**	
	Membership Report Dr. Robertson presented the membership report. Slight decline in Medi-Cal line of business membership. Slight increases in CMC membership.	
	Pharmacy Dashboard Dr. Otomo presented the Pharmacy Dashboard. For Medi-Cal line of business, prior authorization volume has been steady over the last 5 months. Turnaround time is compliant at 100% for 24 hour turnaround time. For Cal MediConnect line of business, prior authorization volume increased in August. Turnaround time is compliant at 100% for standard and expedited prior authorizations. IRR is scheduled for last half of 2018. 10 to 15 cases are selected for review.	

	CMR completion rate goal increased from 22% to 40% for CY2018. There was a 28% CMR completion rate as of the July MTM report.	
	Drug Use Evaluation Results Dr. McCarty presented the Drug Use Evaluation Results 3Q18. 52.7% success rate for Statin use in persons with diabetes 3Q17 intervention.	
	Drug Utilization & Spend Review Dr. McCarty presented the Spend and Trend Overview. For both CMC and Medi-cal, diabetes remains the top spend. For CMC there was a drop in behavioral health drugs and inflammatory disease.	
6	**Discussion and Recommendations for changes to SCFHP Cal MediConnect Formulary & Prior Authorization Criteria**	
	Dr. Huynh presented an overview of the MedImpact 2Q2018 P&T minutes as well as the MedImpact 3Q2018 P&T Part D Actions.	Upon motion duly made and seconded the MedImpact 2Q2018 P&T Minutes, and MedImpact 3Q2018 P&T Part D Actions were approved as submitted.
7	**Discussion and Recommendations for Changes to SCFHP Medi-Cal & Healthy Kids Formulary & Prior Authorization Criteria**	
	Formulary Modifications Dr. Otomo presented the formulary changes since the last P&T meeting. Of note: Trospium tablet added with quantity limit of 2 per day. Removed brand Makena and Epogen from formulary. Retacrit added to formulary with prior authorization and quantity limit 12/28 days.	Upon motion duly made and seconded, formulary modifications were approved as presented.
	DHCS Medi-Cal CDL Updates & Comparability Dr. McCarty presented DHCS Medi-Cal CDL Updates & Comparability. For June 2018, added Inotuzumab Ozogamcin, Copanlisib with Code 1 restriction added. Added Code 1 restriction to Gemtuzumab Ozogamicin. Strength added to Nivolumab, Ibrutinib, Olaratumab, and Pantoprazole Sodium. Removed authorization required from Pantoprazole Sodium, with 2 per day quantity limit applied. Added Apalutamide, Efavirenz/Lamivudine/Tenofovir/Disoproxil Fumarate (Carve out) with Code 1 Restriction. Strength added to Brigatinib. All covered contraceptive products removed restricted to one 13 month supply within a 90 day period. Added restricted to a maximum quantity of up to 18 cycles per dispensing. The maximum supply is intended for	Upon motion duly made and seconded, formulary recommendations were approved as presented.

	clients on a continuous cycle. A 12 month supply of the same product of oral contraceptive may be dispensed twice in one year.	
	Prior Authorization Criteria Dr. Duyen Nguyen presented the following PA criteria for approval by the committee: New and Changes to Criteria: 1. Retacrit 2. Hepatitis C 3. Humira 4. Enbrel 5. Myrbetriq 6. Nicotrol Annual Review (no changes): 1. Proventil 2. Emend 3. Penlac 4. Duragesic 5. Brand Name 6. Compounded Medications 7. Off-label 8. Opioid Reauthorization	Upon motion duly made and seconded, prior authorization criteria were approved as presented.
	New Drugs and Class Reviews Dr. McCarty presented the following new drug reviews: 1. Crysvita- recommended continue as non-formulary. Allowed through formulary exception process (PA). 2. Tavalisse – recommend continue as non-formulary. Allowed through formulary exception process (PA). 3. Doptelet – recommend continue as non-formulary. Allowed through formulary exception process. 4. Palynziq-recommend continue as non-formulary. Allowed through formulary exception process. 5. Epidiolex-recommend continue as non-formulary. Allowed through formulary exception process. 6. Braftovi/Mektovi-recommend continue as non-formulary. Allowed through formulary exception process. New Derivatives, Formulation, & Combinations: 1. Balcoltra-recommend continue as non-formulary. Allowed through formulary exception process.	Upon motion duly made and seconded, all recommendations were approved as presented.

	2. Jynarque- recommend continue as non-formulary. Allowed through formulary exception process. 3. Osmolex ER- recommend continue as non-formulary. Allowed through formulary exception process. 4. Yonsa- recommend continue as non-formulary. Allowed through formulary exception process. 5. RoxyBond- recommend continue as non-formulary. Allowed through formulary exception process. 6. Imvexxy- recommend continue as non-formulary. Allowed through formulary exception process. 7. Intrarosa- recommend continue as non-formulary. Allowed through formulary exception process. 8. Siklos- recommend continue as non-formulary. Allowed through formulary exception process. Bisimilar: Retacrit and Fulphila. Propose continue Retacrit as formulary with prior authorization. Continue Fulphila as non-formulary. HAE, haTTR and Continuous Glucose Monitoring	
	Reconvene in Open Session Committee reconvened to open session at 7:55 p.m.	
8	**Discussion Items**	
	Update on New Drugs and Generic Pipeline Dr. McCarty presented the generic pipeline for 3Q2018, 4Q2018, 1Q2019. High impact drugs: Letairis, Adcirca, Remodulin, Cialis, Tracleer, Byetta, Kaletra, Nuvaring and medium/low impact drugs: Acanya, Abastral, Levitra, Moviprep, Delzicol, Flector, Androgel, Astagraf XL, Onfi, Staxyn, Finacea Gel, Rapaflo, Canasa, Zyclara, Ranexa, Solodyn, Faslodex, and Tekturna.	
9	**Adjournment at 8:00 PM**	

_____ Date 12/13/18

Jimmy Lin, MD, Chair
Pharmacy and Therapeutics Committee Chairperson

Santa Clara Family Health Plan™

MINUTES
UTILIZATION MANAGEMENT COMMITTEE
October 17, 2018

Voting Committee Members	Specialty	Present Y or N
Jimmy Lin, MD, Chairperson	Internal Medicine	Y
Ngon Hoang Dinh, DO	Head and Neck Surgery	Y
Indira Vemuri, MD	Pediatrics	Y
Dung Van Cai, MD	OB/GYN	Y
Habib Tobaggi, MD	Nephrology	Y
Jeff Robertson, MD, CMO	Managed Care	Y
Ali Alkoraishi, MD	Adult and Child Psychiatry	Y

Non-Voting Staff Members	Title	Present Y or N
Christine Tomcala	CEO	N
Lily Boris, MD	Medical Director	Y
Jana Castillo	Utilization Management Manager	Y
Sandra Carlson	Health Services Director	Y
Caroline Alexander	Administrative Assistant	N
Sherry Holm	Behavioral Health Director	N

ITEM	DISCUSSION	ACTION REQUIRED
I. /II. Introductions Review/Revision/Approval of Minutes	Meeting was started with a Quorum at 6:05 PM. There was a motion to approve the July 18, 2018 minutes.	Minutes approved as presented.
III. Public Comment	No public comment.	

ITEM	DISCUSSION	ACTION REQUIRED
IV. CEO Update	Dr. Robertson presented the CEO update. The health plan moved to new location on July 30th. Participated in CMS audit, now working on corrective actions. New Chief Medical Officer Laurie Nakahira starts on October 31st.	
V. Old Business/Follow up items	Ms. Castillo presented some follow up items from the July 18th UM committee meeting. Presented authorization data for gastric bypass as well as criteria for gastric bypass. Six authorizations were pulled for date range of June 1st to August 31st of 2018. Age range of members ranged from 26 to 59 years of age, BMI ranged from 39 to 63. Reviewed guidelines for Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy as well as with Gastric Bypass.	No action required.
VI. Action Items	a. Prior Authorization Grid approval Ms. Castillo presented the 2019 Prior Authorization Grid. New grid combines all lines of business. Created a separate grid for medications (2019 Medical Benefit Drug Prior Authorization Grid). b. UM Program Evaluation 2017 Cal MediConnect Ms. Castillo presented the 2017 UM Program Evaluation for Cal MediConnect. Santa Clara Family Health Plan evaluates its Utilization Management (UM) Program annually to determine their overall effectiveness, identify needed improvements, and assess progress toward improvement of annual goals. The annual evaluation is also used to identify goals, trends, work plan activities, and opportunities for improvement in the coming year. SCFHP has a UM Program that objectively monitors and evaluates appropriate UM services delivered to members which operates with the principles outlined in the program. The UM Program consists of comprehensive and systematic functions, services, and processes that provide care management to members, and include medical necessity determinations regarding the appropriateness of health care services in accordance with definitions contained in the member certificate of coverage.	Approved as presented. Approved as presented.

ITEM	DISCUSSION	ACTION REQUIRED
VII. Reports	The 2017 UM program evaluation resulted in program changes. The UM program and UM policies were described to have it available for members and providers, the UM staff description was updated as staffing changes and expansion were implemented in mid-2017, Practitioner and member satisfaction monitoring were included, and Behavioral Health staff involvement was defined. These changes are outlined in the 2018 Program description. They are made to meet regulatory requirement and to ensure effectiveness of the program structure. UM continues to strive to meet regulatory requirements that are written in the 2018 UM Program description and to meet goals described in the 2018 UM work plan a. Membership Dr. Robertson presented the update on membership. As of October, membership is at 255,311. Membership remains flat. b. UM Reports 2018 i. Dashboard Metrics Dr. Boris presented the Dashboard Metrics report. Monitoring compliance based on turnaround time. Divided by lines of business. For CMC line of business, at 99.5% of compliance for routine requests, 98.7% compliant for expedited/urgent requests, 96.8% compliant for retro requests. For Medi-Cal line of business, 98.7% compliant for routine, urgent 99.4 %, retro 99.3%. Have implemented outbound calls to members and providers. Call member and inform them authorization is approved, fax provider immediately with letter and follow up with a call. ii. Standard Utilization Metrics Data is for July 1, 2017 to June 30, 2018. For MediCal/non SPD, discharges per thousand is at 3.68, with average length of stay 3.55. For Medi-Cal SPD discharges per thousand are at 11.82. Average length of stay 4.83. For CMC population 6.11 days average length of stay. Discharges per thousand 267.7. For NCQA Medicaid Benchmark Comparisons, Non SPD fall at less than 10%, SPD falls at greater than 90%. Combined total is less than 50% percentile ranking for average length of stay. Medi-Cal SPD's 141.9 discharges per thousand, CMC is at 262.7 per thousand. Average length of stay is 4.83 for Medi-Cal SPD and 6.11 for CMC. Inpatient Readmissions Medi-Cal Non SPD is at 15.57%. SPD Inpatient Readmissions for Medi-Cal overall average of 21.71%. Readmissions on CMC at 16.5%. NCQA Benchmark comparison for CMC Readmissions: Ages 18 to 64 readmission rate of 24.01%; Ages 65+	

ITEM	DISCUSSION	ACTION REQUIRED
	readmission rate of 13.52%. For age 18 to 64, greater than 90th percentile ranking, age 65+, greater than 50th percentile ranking. (Lower rate indicates better performance). Frequency of selected procedures have ranged where they have been. c. HS 04.01 Reporting Quality Monitoring of Plan Auths, Denials etc. (Q3 18) Ms. Castillo presented the Q3 2018 Quality Monitoring Report. Santa Clara Family Health Plan (SCFHP) completed the 3nd quarter review for timely, consistent, accurate and understandable notification to members and providers regarding adverse determinations. For the 3nd Quarter review of 2018, the findings are as follows: A. For the dates of services and denials for July, August and September of CY 2018 were pulled in the 3rd quarter sampling year. a. 30 unique authorizations were pulled with a random sampling. i. 57% or 17/30 Medi-Cal LOB and 43% or 13/30 CMC LOB ii. Of the sample 100% or 30/30 were denials iii. Of the sample 40% or 12/30 were expedited request; 60% or 18/30 were standard request. 1. 100% or 12/12 of the expedited authorizations met regulatory turnaround time of 72 calendar hours 2. 89% or 16/18 of the standard authorizations met regulatory turnaround time, 11% or 2/18 are non-compliant with regulatory turnaround time (5 business days for Medi-Cal LOB and 14 calendar days for CMC LOB) iv. 67% or 20/30 are medical denials, 33% or 10/30 are administrative denials v. 93% or 28/30 of cases were denied by MD, 7% or 2/30 cases were denied by a pharmacist vi. 100% or 30/30 were provided member and provider notification. vii. 58% or 7/12 expedited authorizations were provided oral notifications to member. viii. 83% or 25/30 of the member letters are of member's preferred language. ix. 100% or 30/30 of the letters were readable and rationale for denial was provided. x. 97% or 29/30 of the letters included the criteria or EOC that the decision was based upon.	

ITEM	DISCUSSION	ACTION REQUIRED
	xi. 100% or 30/30 of the letters included interpreter rights and instructions on how to contact CMO or Medical Director Manager of Utilization Management and Director of Health Services reviewed the findings of this audit and recommendations from that finding presented to UMC are as follows: • Provide staff training regarding oral notification to member following an expedited service authorization determination. • Provide staff training in managing regulatory turnaround time based on LOB. • Monitor other causes of untimeliness such as FDRs and escalate it to compliance. • Provide staff training in checking member's preferred language when sending member's UM letters. • Continue QA monitoring and reporting. d. Referral Tracking Ms. Castillo presented the Referral Tracking report for Q318. Not much claims authorization activity in August. Do a 3 month look back. 56.8% of authorizations have matched a claim for Cal Medi-Connect line of business. 55% of authorizations have matched a claim for Medi-Cal line of business. Do outbound calls to members to find out why the appointment was never attended or scheduled. Present to UM committee the findings. Dr. Tobaggi asked if there are members complaining they are not getting appointments and why we are doing these statistics. Dr. Boris explained DMHC requested data. e. Nurse Advice Line Stats Ms. Carlson presented the Nurse Advice Line Stats. Medi-Cal received 942 calls, Healthy Kids 15 calls, Cal MediConnect calls 45 during the third quarter of 2018 (September 2018 data not yet received). For Medi-Cal 31 triage dispositions rendered to call 911/EMS immediately. For Cal MediConnect, 4 triage dispositions were rendered to call 911/EMS immediately. For Health Kids, no triage dispositions rendered to call 911/EMS immediately. Highest volume for Triage Guidelines used for call types: Medi-Cal-CareNet Health Information only, Abdominal/Pelvic Pain, Abnormal vaginal bleeding, urinary symptoms (female), allergic reactions	

ITEM	DISCUSSION	ACTION REQUIRED
	Healthy Kids-CareNet Health Information only, Bites, Stings, Rash/Hives, Nasal allergies, Eye pus or discharge Cal MediConnect- CareNet Health Information only, BP Control problems, Insect bites/stings f. Interrater Reliability (Medical & Behavioral Health Q3) Twice a year staff is tested. Results are presented to UM Committee. For UM staff only 3 of 21 staff did not pass with score of 80% or higher. Most common reason was improper identification of required turnaround time for specific lines of business. Also lack of understanding for specific Care Coordinator guidelines and improper selection and application of clinical guidelines for medical review. The corrective action's plan after identifying the common findings are: • Mandatory remedial training and with retest for staff that were found non proficient within 1 month of the IRR test. Completed on 10/5/2018. • Continued training to all UM and MLTSS staff for all UM process and workflows to comply with regulatory standards. • UM management weekly monitoring as outlined in UM procedure and quarterly report to UM committee. Summary of the IRR remedial training: Attendees: All staff that were found non proficient in the IRR testing (1 coordinator and 2 licensed staff). Discussion topics: • Identification of lines of business • Regulatory turnaround time based on line of business • Care Coordinator Guidelines • UM Policy and procedure for Hierarchy of clinical criteria • Selection and application of clinical criteria, specifically MCG Retesting: 3 recreated hypothetical cases Scoring and passing score follows the same procedure as the IRR testing. All 3 staff that attended the remediation were re-tested and were found proficient. For behavioral health staff, 1 out of 3 staff did not pass with score of 80% or higher. Personal Care coordinator (PCC) was provided additional training on 9/27/18 and passed the re-test with a score of 90%. Retest was provided on 9/28/18. Findings were staff who are currently authorized to review/approve BH services through SCFHP express comfort in knowing the process/where to go for	

ITEM	DISCUSSION	ACTION REQUIRED
	clarification. While ongoing support throughout the department is provided, additional training is required for new PCC to review process of authorizations. This training was provided on 9/27/2018 and retesting completed on 9/28/2018. The corrective action's plan after identifying the common findings are: • Mandatory remedial training with post testing for all non-proficient staff • Mandatory bi-annual review of guidelines and criteria, as well as biannual testing, will continue to be scheduled for all staff who complete Behavioral Health Authorizations.	
VIII. Behavioral Health UM Reports	Dr. Boris presented the Dashboard Metrics reports for Behavioral Health. Divided by lines of business. For CMC line of business, at 100% of compliance for routine requests, 100% compliant for expedited/urgent requests, 100% compliant for retro requests. For Medi-Cal line of business, 95.3% compliant for routine, urgent 85.7 %, retro 98.8%. Have implemented outbound calls to members and providers.	Pull 6 months of data for LTSS and present at next UM committee meeting

ITEM	DISCUSSION	ACTION REQUIRED
IX. Adjournment	Meeting adjourned at 7:30 PM	

Santa Clara Family Health Plan™

ITEM	DISCUSSION	ACTION REQUIRED
NEXT MEETING	The next meeting is scheduled for Wednesday, January 16, 2019, 6:30 PM	

Prepared by: _____ MD Date 2/1/19
Caroline Alexander
Administrative Assistant

Caroline resigned 2018/Dec
BOARS. MD RVWD FINAL
DOCUMENT

Reviewed and approved by: _____ MD Date 2/1/19
Jimmy Lin, M.D.
Committee Chairperson

CHAIR FOR DR LYNN
LBORS. MD

Compliance Department Activity
September – Mid-November 2018

2018 CMS Program Audit of CMC

CMS issued a preliminary audit report on September 7, 2018. There were findings in each of the audit areas. Following final submission of root cause and impact analyses, on October 3, 2018, CMS issued an Immediate Corrective Action Required (ICAR) Notification letter, identifying 7 conditions requiring immediate corrective action. These were in the areas of Part D Formulary and Benefit Administration (FA), Part D Coverage Determinations, Appeals, and Grievances (CDAG), and Service Authorization Requests, Appeals and Grievances (SARAG). The Corrective Action Plans were due three days after the notification. The ICARs were submitted and have recently been accepted. The Plan is now awaiting its draft final audit report.

DMHC Audit(s)

The Department of Managed Health Care (DMHC) preliminary report regarding its findings was due on or before August 6. However, as of today, the audit report is still pending.

On October 19, 2018, DMHC notified the plan that it would be conducting a Routine survey of the Plan starting on March 18, 2019. The agency has requested a large volume of documents to cover the audit period of November 1, 2016 through October 31, 2018. Compliance is working with the business units to collect the information, which is due to DMHC by Monday, November 19, 2018.

2018 DHCS Audit

The Department of Health Care Services (DHCS) issued the final audit report from its April 2018 audit on September 11, 2018. DHCS requested corrective action plans for 7 findings. CAPs were submitted in early October. Currently DHCS is requesting additional documentation for some of the CAPs.

DHCS has confirmed that rather come out in April 2019 for its annual audit, it will conduct a joint audit with DMHC in March 2019. The practical reality is that we will have two separate audits at the same time, although we anticipate that DHCS and DMHC will jointly staff on the various contract and regulatory requirements. DHCS will issue a data request in early 2019.

Delegate and Internal Corrective Actions Plans Issued:

- Premier Care:
  - 1 for the Annual Audit (HIPAA breach reporting w/in 24 hours of identification, no indication of board-certification for staff making medical necessity determinations, Incorrect NOA letter)

  CAP due November 9, 2018.

- Physicians Medical Group:
  - 1 for the Claims Audit (accurate claims processing, PDR processing)
  - 1 for the Annual Audit (wait time and accessibility of services monitoring)

  CAP responses received and business unit reviewing.

- CHME
  - 1 for Annual Audit (FWA Training and HIPAA breach reporting within 24 hours of identification, use of clinical criteria for UM decisions, Encounter data submission/resubmission, and eligibility file processing)
  - CAP issued (CMC & MC) for untimely delivery of DME Supplies
  - Focus Audit and monthly Monitoring:
    - Timeliness of UM Decision making (all LOB)
    - Call Center Operations (all LOB)
    - Notice of Action Letters

  CAP responses under review by Business Units.

- Claims Department
  - Claims faxes and PDRs were being routed to the wrong email box (junk email box) and this was not identified for two months because PDRs and claims were still coming through.
  - 660 PDRs came in. 250 were out of compliance for the timeframe for processing. The majority of the cases were Medi-Cal. All cases have been resolved at this time. Claims recently submitted a corrective action to ensure this does not happen in the future. It is currently under review by Compliance.

  Corrective Action Plan accepted.

- Docustream
  - Annual audit findings:
    - FWA Training
    - System Breach Process

  CAP responses under review by Business Units.

- Language Line
  - Annual Audit findings:
    - Availability of Interpreter Services 24/7
    - No documentation of C&L Training
    - No documentation of language self-assessment

  Vendor wants to discuss findings and CAP further. Call to be scheduled.

Operational Compliance Report – Corrective Actions

- Enrollment's CAP appears to be working with improvement of the two measures to 100% compliance.
- Customer Service's measures have shown a positive trend upward, however, they remain below goal. **Customer Service will be asked to provide an updated Corrective Action Plan.**
- Case Management continues an upward trend for CMC HRA and ICP completion. However, they do not have numbers for SPD HRAs. **Case Management will be asked to submit a work plan on how they will bring this element into compliance.**
- Claims measures dropped in August but have returned to 100%.

- Grievance and Appeals rates tend to fluctuate greatly for CMC and Medi-Cal with a negative trend downward for several of the elements. **Grievance and Appeals will be asked to update their work plan for how they plan to achieve compliance in 2019.**
- New hire training within 10 days was not met because General Compliance training was not implemented until August 1, 2018. New hires have been receiving the training since.
- Key Personnel Filings continue to be out of compliance due to inability to obtain required documents from Board members within 5 days of appointment. The Compliance Department is working on strategies to improve the process and outcomes.

Joint Operations Committee Meetings

The following Joint Operations Committee Meetings were held:

September:

County Mental Health, Kaiser, PMG, Premier Care, VHP, and HealthLOGIX,

October:

Carenet, Liberty Dental, MedImpact, VSP, Docustream, Language Line

November:

Advanced Health, CHME, Premier Care, T&M Protection Services and scheduled PMG, VHP

December:

There are 4 JOCs scheduled for December.

Cal MediConnect

- CMS Audit CAPs have kept everyone busy.
- No other Notices of Non-Compliance were received from CMS.
- CMT Calls
    - September 2018 – CMT asked questions regarding the CMC Consumer Advisory Committee (e.g. strategies for recruitment, membership, how orient, what do you ask members for feedback on, etc.)
    - October 2018 – CMT inquired about the difference between Q1 and Q2 Core 3.2 data regarding the % of members documented as "unwilling to complete a care plan" and about strategies to improve performance on quality withhold measures.
    - November 2018 – CMT and Plan discussed CY 2019 Readiness and Behavioral Health Integration Coordination.

Medi-Cal

- DHCS issued Contract Amendment 26 for signature. It was missing rates and DHCS will be issuing a subsequent amendment to reflect Final SFY16/17 rates as submitted to CMS on 9/20/17 in Package 48.
- DHCS issued the 2019 Auto Assignment calculations. SCFHP will receive 67% of the members who have not selected a health plan when enrolling in Medi-Cal and Anthem Blue Cross will receive 33%.
- Children enrolled in the Pediatric Palliative Care Waiver will be receiving their palliative care services through the managed care plans effective 1/1/2019. Currently, SCFHP does not have any members in the Pediatric Palliative Care waiver program.
- Work continues for implementation of the Health Homes Program in Santa Clara County in July 2019

- DHCS published two key All Plan Letters: an updated "Blood Lead Screening of Young Children" and "Diabetes Prevention Program". These will be pushed out to providers.

DMHC

- 19 DMHC Complaints have been received from September to present. Currently only 1 case has gone to IMR.

HIPAA Disclosures

There have been 5 potential disclosures between September and mid-November that were reported to DHCS and required investigation.

- ID card to the wrong member
- Wrong member information in transportation portal. However, it was a test using the member name but no other identifying information.
- Grievance PHI bin was emptied by janitorial staff and had copies of some member PHI.
- PMG sent an auth letter to the wrong member.
- Website search function reconfigured incorrectly allowing claims dispute documents to be searchable by the public.

FWA Activities

T&M provided an updated summary report detailing its recent SIU activities. The activities included:

- Datamining Activities:
  - Reviewed hospice HCPCS codes (Q5001 – Q5010), awaiting contracts of several providers from SCFHP.
  - Reviewed 2 dermatologists pharmacy claims data.
  - Reviewed home blood glucose monitor (E0607) recipients and DME providers.
  - Reviewed P9603 and P9604 – Travel allowance for specimen collection
  - Reviewed SCFHP's exposure to Professional Clinical Laboratory (ProLab). OIG recently found ProLab to be non-compliant with Medicare requirements for billing phlebotomy travel allowances.
  - Reviewed medical and pharmacy claims data concerning members in hospice possibly receiving curative drugs.
  - Reviewed HCPCS codes: A9274 (External Ambulatory Insulin) and E0784 (Infusion pumps)

- Upcoming Activities:
  - Review of Community-Based Adult Services/Adult Day Health Care claims
  - Review of Hospitals claims data
  - Review of Skilled Nursing Facility providers

- Active Investigations:
  - 1 Active investigation that should be completed next week.

- 5 provider investigations for potential E&M upcoding and CPT Code 95004 Top Biller requiring collection of medical records and contact of members to verify services rendered.
- 1 hospital investigation for upcoding requiring collection of medical records and further review
- 2 durable medical equipment (DME) providers investigated for inappropriate CPAP billing. Overpayment notices to be mailed to the providers.
- 1 transportation provider investigated for potential billing discrepancies. Further review requires collection of medical visit data evaluated against billing.
- 6 clinic investigations, 4 of which resulted in overpayment notices being mailed. 2 clinic investigations require collection of medical records and further review.
- 1 ADHC Center with member attendance 93% or higher. Review records from provider and send overpayment notice if necessary.
- Mobile Diagnostic provider – review billings based on CMS directive of pro-rated billings based on the number of patients seen at a location.
- 3 ABA Providers – payments made in excess of contracted rates. Overpayment notice to be mailed.

Santa Clara Family Health Plan™

QUALITY IMPROVEMENT

DASHBOARD

January 2019

QUALITY IMPROVEMENT

DASHBOARD

Quarter 4 2018

Facility Site Review Timeliness	
Completed Timely	**100%**

Potential Quality of Care Issues	
Cases Opened	150
Cases Closed	76
% Closed	**51%**

Initial Health Assessement	
# Enrolled	20,980
# Completed	7494
% Completed	**36%**

Gaps In Care	
Month	# Alerts Turned Off
October	227
November	88
December	14

QUALITY IMPROVEMENT

DASHBOARD - CAHPS / HOS - CMC Only

Santa Clara Family Health Plan

CAHPS Results					
Measure	**2016 Results**	**2017 Results**	**2018 Results**	**2018 CA MMP**	**Trend**
C03 - Annual Flu Vaccine	83%	77%	82%	69%	
C23 - Getting Needed Care	N/A	3.17	3.25	3.36	
C24 - Getting Appointments and Care Quickly	3.09	3.02	3.15	3.23	
C25 - Customer Service	N/A	N/A	3.52	3.64	
C26 - Rating of Health Care Quality	N/A	8.2	8.3	8.4	
C27 - Rating of Health Plan	8.3	8.2	8.4	8.6	
C28 - Care Coordination	N/A	3.5	3.47	3.5	
D07 - Rating of Drug Plan	8.4	8	8.4	8.5	
D08 - Getting Needed Prescription Drugs	N/A	N/A	3.63	3.63	

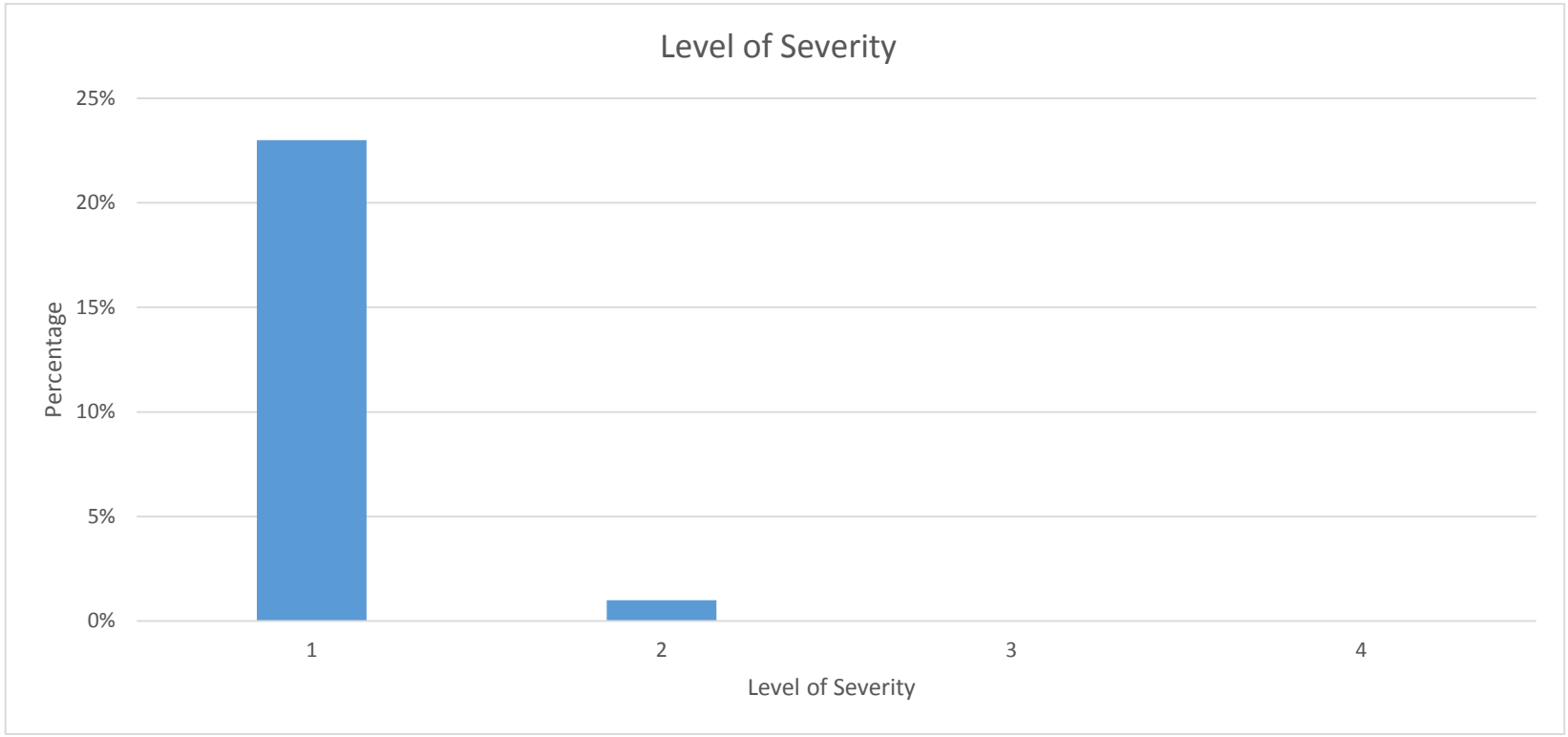
HOS Results			
Component	**2016 Results**	**2017 Results**	**2017 Baseline**
Physical Component Score	36.4	35.2	39.1
Mental Component Score	49.7	48.7	52.8
General Health			
Excellent to Good	54.8%	46.9%	71.1%
Fair to Poor	45.2%	53.1%	28.9%
Self- Rated Physical Health Compared to One Year Ago			
Much Better to About the Same	64.1%	60.9%	73.3%
Slightly Worse or Much Worse	35.9%	39.1%	26.7%
Self-Rated Mental Health Compared to One Year Ago			
Much Better to About the Same	81.30%	75.5%	87.0%
Slightly Worse or Much Worse	18.70%	24.5%	13.0%

QUALITY IMPROVEMENT

DASHBOARD - Potential Quality of Care (PQI) Issues

Quarter 4 2018

Potential Quality of Care Issues	
Cases Opened	150
Cases Closed	76
Percent Closed	**51%**



QUALITY IMPROVEMENT

DASHBOARD - Potential Quality of Care (PQI) Issues

Data as of January 25, 2019

Santa Clara Family Health Plan™

# of PQI's Opened

Month	# of Open PQIs
October 2018	64
November 2018	49
December 2018	37
Total	150

Closed PQIs

October 2018	Level of Severity			
Network	1	2	3	4
10	4	0	0	0
20	13	9	0	0
30	0	0	0	0
40	0	0	0	0
50	4	0	0	0
60	3	0	0	0
Total	24	9	0	0

November 2018	Level of Severity			
Network	1	2	3	4
10	1	0	0	0
20	9	2	0	0
30	0	0	0	0
40	0	0	0	0
50	1	1	0	0
60	0	0	0	0
Total	11	3	0	0

December 2018	Level of Severity			
Network	1	2	3	4
10	0	1	0	0
20	0	4	0	0
30	0	0	0	0
40	0	0	0	0
50	0	1	0	0
60	0	0	0	0
Total	0	6	0	0

Total PQIs Received	150

Total Closed To Date					
	Level of Severity				
Network	**1**	**2**	**3**	**4**	**Total**
10	5	0	0	0	6
20	22	11	0	0	33
30	0	0	0	0	0
40	0	0	0	0	0
50	5	1	0	0	7
60	3	0	0	0	3
Total	35	12	0	0	49
Percentage	23%	1%	0%	0%	

QUALITY IMPROVEMENT

DASHBOARD - Facility Site Reviews (FSR)

Quarter 4 2018

Santa Clara Family Health Plan™

Facility Site Reviews	October 2018	November 2018	December 2018	Total
month	1	3	1	5
# of FSRs completed	1	3	1	5
# of FSRs that passed	1	2	1	4
# of FSRs with corrective action	1	3	1	5
% of FSRs completed timely	100.0%	100.0%	100.0%	100%

QUALITY IMPROVEMENT

DASHBOARD - Initial Health Assessment (IHA)

Santa Clara Family Health Plan™

SCFHP Completion - Q4 2018

Initial Health Assessment	October 2018	November 2018	December 2018	Total
# of members eligible for an IHA	2,933	2,345	2,834	8,112
# of IHA completed within 120 days of enrollment	1,266	1,223	1,365	3,854
% of IHA completed within 120 days of enrollment	43.2%	52.2%	48.2%	47.5%

Specific Network IHA Completion - Q3 2018

Initial Health Assessment	Network					
	10	20	30	40	50	60
# of members eligible for an IHA	3395	21129	3358	1010	7525	1793
# of IHA completed within 120 days of enrollment	1775	9428	2151	584	3692	1010
% of IHA completed within 120 days of enrollment	52.28%	44.62%	64.06%	57.82%	49.06%	56.33%

QUALITY IMPROVEMENT

DASHBOARD - Quality Projects

Quarter 4 2018

Santa Clara Family Health Plan™

Incentives - Medi-Cal

Incentive	Eligible Members	Incentive Received	Q4 Percentage
Controlling High Blood Pressure	986	36	4%
Childhood Immunization Status - Combo 3	350	18	5%
Comprehensive Diabetes Care - Nephropathy	212	13	6%

Prenatal Program

Incentive	Incentive Received
Gift Card	59
Carseat	31
Sleep Pod	40

Performance Improvement Project - Cal MediConnect

Individual Care Plan Completion

Study Indicator	Completion Goal	Quarter 3
High risk members	63%	66.93%
Low risk members	61.80%	67.06%

MINUTES

For a Regular Meeting of the

SANTA CLARA COUNTY HEALTH AUTHORITY
PROVIDER ADVISORY COUNCIL (PAC)

Wednesday, February 13, 2019, 12:15 – 1:45 PM
Santa Clara Family Health Plan
Boardroom
6201 San Ignacio Ave, San Jose, CA 95119

COMMITTEE MEMBERS PRESENT
Chung Vu, MD
Clara Adams, LCSW
David Mineta
Jimmy Lin, MD
Meg Tabaka, M.D., Resident
Peter Nguyen, MD
Sherri Sager
Thad Padua, MD, Chair

STAFF PRESENT:
Christine Tomcala, CEO
Laurie Nakahira, DO, CMO
Jeff Robertson, MD, Medical Director
Eric Tatum, Director, PNM
Johanna Liu, Director, RX & QI
Jana Castillo, Manager, UM

COMMITTEE MEMBERS ABSENT
Bridget Harrison, MD
Dolly Goel, MD
Kingston Lum

OTHERS PRESENT:
Jana Castillo, RN, BSN, Mgr, UM
Dang Huynh, Pharm.D, Mgr, RX Department
Robyn Esparza, Admin Asst, PNM

ROLL CALL/ESTABLISH QUORUM

Thad Padula, MD, Chair, called the meeting to order at 12:24 pm.

- Roll call was taken and a quorum was established at 12:25.
- Introduction of new Council members:
  - ✓Clara Adams, LCSW

1. **MEETING MINUTES (ATTACHMENT S)**

   The previous minutes from November 14, 2018 were reviewed
   - November 14, 2018 minutes were approved with two minor revisions.

2. **PUBLIC COMMENT**
   - There were no public comments.

3. **CHIEF EXECUTIVE OFFICER UPDATE (ATTACHMENT 🗐)**
Christine Tomcala, CEO, presented the January 2019 Membership Summary (copy attached herein), noting no dramatic changes in the current enrollment (251,000):

- Healthy Kids: 3,252 (1%)
- Cal MediConnect: 7,750 (3%)
- Medi-Cal: 239,998 (96%)

Total: 251,000 (100%)

With regard to Medi-Cal Membership by Age Group the following was noted:

- Pediatrics: 97,516 (41%)
- Adults: 142,482 (59%)

Total: 239,998 (100%)

The following current event was noted:

- Regulatory Audits and NCQA Survey

  Ms. Tomcala briefed the Council on the CMS and DHCS audits and also the recent NCQA survey. She stated that CMS has accepted SCFHP's Corrective Action Plan that was submitted after CMS audited SCFHP's Cal MediConnect product. Next, she advised the Council that the Plan is currently preparing for a DHCS audit that will take place in March.

  In addition, Ms. Tomcala stated that NCQA was recently onsite for two-days to audit the Plan's Cal MediConnect product. She said that that the Plan doesn't have the final results yet, but believes it went well and should have good news the next time we meet. Ms. Tomcala praised the effort of the Plan's staff, and specifically noted the diligent efforts of the Medical Management team on preparing for the NCQA audit.

  - No action required. Informational only.

4. **QUALITY AND PHARMACY (ATTACHMENT 🗐)**
Dr. Johanna Liu, Director of RX and QI, presented drug utilization reports on the Top 10 Drugs by Total Cost and Top 10 Drugs by Prior Authorization for the date range October 1, 2018 – December 31, 2018 (Copy Attached Herein).

   - No action required. Informational only.

5. **CME ON MARCH 5TH 2019 ON NEURODEVELOPMENTAL DISORDERS & BEHAVIORAL HEALTH TREATMENT (ATTACHMENT 🗐)**
Dr. Robertson, Medical Director, advised the Council members of an upcoming Continuing Education Program on Neurodevelopmental Disorders and Behavioral Health on March 5, 2019 at Fiorillo's Restaurant. The keynote speakers will be Manmeet K. Rattu, Psy.D. and Jesse Lam, Psy.D. Attendees will be entitled to two hours of CEU/CME credits.

   - The Council members were instructed to complete the registration form and return it if they are interested in attending.

6. PRIOR AUTHORIZATION GRID (ATTACHMENT 🗐)

Ms. Jana Castillo, Manager of Utilization Management, presented the finalized 2019 Medical Services Prior Authorization Grid and the 2019 Medical Benefit Drug Prior Authorization Grid (copies attached herein). She stated that the grids are no longer separated by lines of business, which makes it a much cleaner and easier to understand.

- No action required. Informational only.

7. MEMBERSHIP OF PAC

Dr. Nakahira stated that she would like to take a new look at the membership of the Council. She has reviewed the 6 C's and wants to focus on providers in the community and how the Council can support quality improvement. She is currently reviewing HEDIS and Quality measures. She would like to hear Council members' best practices and would like to coordinate initiatives to improve our scores collaboratively. She noted that appointed Council members are required to attend a minimum of two meetings per year. Ms. Sherri Sager reminded the Council that she has two Pediatric residents that are very interested in joining the Council

The Council then discussed a number of quality measures. They voiced concern over the need to see all new patients within 120 days of enrollment. Dr. Padua agreed that it is difficult to accomplish this task in this timeframe and noted that there is usually inaccuracy in the report as some patients have already been seen. Council members stressed the importance of focusing on the patient's healthcare, rather than excessive paperwork and audits.

Dr. Robertson indicated that the regulatory bodies have requirements and they want statistics. He noted that SCFHP has a compliance rate that is below other health plans in the state. He knows that providers are doing quality work and that it's just a matter of capturing the data. He advised that if a patient declines the screening, then the office just needs to document this information in the health record in order for the Plan to receive the appropriate credit.

Dr. Nakahira noted that the Plan's Information Technology Department is working on an initiative to capture the data in physician's EMRs. Dr. Padua stressed that there is a need for assistance from the health plan to reduce administrative burdens of its contracted physicians and specifically requested assistance with the following: HEDIS measures, the requirement to see patients with 120 days of enrollment, and the developmental delay screenings.

- Health Plan representatives to present solutions to reduce administrative burdens of contracted physicians with HEDIS, 120 day health screenings and developmental delay screenings.

8. CONFIDENTIALITY AGREEMENT

Council members were asked to sign their annual Confidentiality Statement.

- Statements to be filed accordingly.

9. DISCUSSION / RECOMMENDATIONS

- There were no further discussion / recommendations.

10. ADJOURNMENT

It was moved, seconded and approved to adjourn the meeting at 1:27pm. The next meeting is scheduled for Wednesday, May 8, 2019. A meeting reminder will be sent in the near future, confirming meeting and location.

Dr. Thad Padua, Committee Chairman _____ Date _____

Santa Clara Family Health Plan

Quality Improvement Program 2019

Santa Clara Family Health Plan™

Table of Contents

I. Introduction

The Santa Clara County Health Authority, operating business as Santa Clara Family Health Plan (SCFHP), is licensed under the Knox Keene Act of 1975 and the regulations adopted hereunder as administered by the State of California's Department of Managed Health Care (DMHC). It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County. SCFHP's products also include Health Kids and Cal MediConnect.

- It is a public agency established to enter into a contract with the Department of Health Care Services (DHCS) to serve the Medi-Cal enrollees in Santa Clara County with 242,695 members as of December 2018.
- In 2001, SCFHP commenced providing health care to children enrolling in the Healthy Kids Program. As of December 2018, 3,345 are enrolled in this program.
- In 2015, Centers for Medicare and Medicaid Services (CMS) contracted with SCFHP for the Cal MediConnect (CMC)/Dual Demonstration Project Medicare-Medicaid Plan (MMP). 7,695 members are enrolled in this program as of December 2018.

SCFHP is dedicated to improving the health and well-being of the residents of Santa Clara County and shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. SCFHP is accountable for the quality of all covered services.

II. Mission Statement

The Mission of SCFHP is to provide high quality, comprehensive health coverage for those who do not have access to, or are not able to purchase health care at an affordable price. Working in partnership with select practitioners and providers, SCFHP acts as a bridge between the health care system and those who need coverage.

One of SCFHP's core values is our belief that as a local, public, not-for-profit health plan, we have a unique responsibility to continually improve the health status of the community by incorporating a comprehensive approach to health care and wellness. SCFHP maintains a comprehensive Quality Improvement (QI) Program that systematically monitors and continually drives improvements to the quality of care to our members, provides for culturally and linguistically appropriate services, identifies over- and under- utilization and substandard care, monitors member satisfaction and member safety and takes corrective actions and interventions when necessary.

III. Authority and Accountability

The Santa Clara County Health Authority is an independent public agency that governs SCFHP. Appointed by the County Board of Supervisors, the 13-member Governing Board seeks to improve access to quality health care, maintain and preserve a health care safety net for Santa Clara County, and ensure the fiscal integrity of SCFHP. With the health care industry rapidly evolving, SCFHP benefits greatly from the innovative ideas and perspectives of this diverse group of people with backgrounds in business, finance, managed care, hospital administration, information technology, medicine, health care policy, and law.

SCFHP's Governing Board assumes ultimate responsibility for the QI Program and has established the Quality Improvement Committee (QIC) to oversee this function as a Board committee. This supports the Board playing a central role in monitoring the quality of health care services provided to members and striving for quality improvement in health care delivery. The Board authorizes and designates the Chief Executive Officer (CEO) as the individual responsible for the implementation of the QI Program Description. The CEO has delegated oversight of the day-to-day operations of the QI Program to the Chief Medical Officer (CMO).

IV. Purpose

SCFHP is committed to the provision of a well-designed and well-implemented QI Program. The Plan's culture, systems and processes are structured around its mission to improve the health of all enrolled members. The QI Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation and improvement in the delivery of health care provided to all members, including those with special needs. This systematic approach to quality improvement provides a continuous cycle for assessing the quality of care and services in such areas as preventive health, acute and chronic care, behavioral health, over- and under-utilization, continuity and coordination of care, patient safety, and administrative and network services.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple customers (members, health care providers, and community agencies):

A. It is organized to identify and analyze significant opportunities for improvement in care and service.
B. It will foster the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
C. It is focused on QI activities carried out on an ongoing basis to promote efforts which support improving patient experience of care, improving health of populations and reducing per capital cost of health care.

SCFHP recognizes its legal and ethical obligation to provide members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, the Plan will provide for the delivery of quality care with the primary goal of improving the health status of Plan members. Where the member's condition is not amenable to improvement, the Plan will implement measures to possibly prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the member. The QI Program includes identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the interventions. Whenever possible, the Plan's QI Program supports processes and activities designed to achieve demonstrable and sustainable improvement in the health status of its members, and services received promoting patient safety at all levels of care.

In order to fulfill its responsibility to members, the community and other key stakeholders, regulatory agencies and accreditation organizations, the Plan's Governing Board has adopted the following QI

Program Description. The program description is reviewed and approved at least annually by the QIC and Governing Board.

V. Goals

The goal of Quality Improvement is to deliver care that enables members to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:

A. Quality of physical health care, including primary and specialty care.
B. Quality of Behavioral Health services focused on recovery, resiliency and rehabilitation.
C. Quality of Long Term Support Services(LTSS)
D. Adequate access and availability to primary, Behavioral Health services, specialty health care, and LTSS provides and services.
E. Continuity and coordination of care across all care and settings, and for transitions in care.
F. Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.

Additional goals and objectives are to monitor, evaluate and improve quality of care:

A. The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
B. The important clinical and service issues facing the Medi-Cal and CMC populations relevant to its demographics, high-risk, and disease profiles for both acute and chronic illnesses, and preventive care
C. The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners
D. The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
E. The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
F. Member and provider satisfaction, including the timely resolution of grievances
G. Risk prevention and risk management processes
H. Compliance with regulatory agencies and accreditation standards
I. The effectiveness and efficiency of the Medi-Cal and CMC internal operations
J. The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
K. The effectiveness of aligning ongoing quality initiatives and performance measurements with the organization's strategic direction in support of its mission, vision, and values
L. Compliance with Clinical Practice Guidelines and evidence-based medicine
M. Support of the organization's strategic quality and business goals by utilizing resources appropriately, effectively, and efficiently
N. Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of

practitioners, contracted hospitals, contracted services, ancillary services, and specialty providers

O. Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals for patient safety and coordination of care.

VI. Objectives

The objectives of the QI Program Description include:

A. Keeping members healthy
B. Managing members with emerging risk
C. Patient safety or outcomes across settings
D. Managing multiple chronic illnesses
E. Drive the quality improvement structure and processes that support continuous quality improvement, including measurement, trending, analysis, intervention, and re-measurement
F. Support practitioners with participation in quality improvement initiatives of SCFHP and all governing regulatory agencies
G. Establish clinical and service indicators that reflect demographic and epidemiological characteristics of the membership, including benchmarks and performance goals for continuous and/or periodic monitoring and evaluation
H. Measure the compliance of contracted practitioners' medical records against SCFHP's medical record standards at least once every three years. Take steps to improve performance and re-measure to determine organization-wide and practitioner specific performance
I. Develop studies or quality activities for member populations using demographic data. Studies and/or activities are designed to identify barriers to improve performance and/or validate a problem or measure conformance to standards. Oversee delegated activities by:
    a. Establishing performance standards
    b. Monitoring performance through regular reporting
    c. Evaluating performance annually
J. Evaluate under and over-utilization, continuity, and coordination of care through a variety of methods and frequencies based upon members' needs. These methods include, but are not limited to, an annual evaluation of:
    a. Medical record review
    b. Rates of referral to specialists
    c. Hospital discharge summaries in office charts
    d. Communication between referring and referred-to physicians
    e. Analysis of member complaints
    f. Identification and follow-up of non-utilizing members
    g. Practice Pattern Profiles of physicians
    h. Performance measurement of practice guidelines
K. Coordinate QI activities with all other activities, including, but not limited to, the identification and reporting of risk situations, the identification and reporting of adverse occurrences from

UM activities, and the identification and reporting of potential quality of care concerns through grievances.

L. Evaluate the QI Program Description and Work Plan at least annually and modify as necessary. The evaluation addresses:
    a. A description of completed and ongoing QI activities that address the quality and safety of clinical care and the quality of services
    b. Trending of measures to assess performance in quality and safety of clinical care and the quality of service indicator data
M. Analysis of the results of QI initiatives, including barrier analysis that evaluates the effectiveness of QI interventions for the previous year (demonstrated improvements in the quality and safety of clinical care and in the quality of services)
N. Recommendations that are used to re-establish a Work Plan for the upcoming year which includes a schedule of activities for the year, measurable objectives, and monitoring of previously identified issues, explanation of barriers to completion of unmet goals, and assessments of goals
O. Implement and maintain health promotion activities and disease management programs linked to QI actions to improve health outcomes. These activities include, at a minimum, identification of high-risk and/or chronically ill members, education of practitioners, and outreach programs to members
P. Maintain accreditation through the National Committee for Quality Assurance (NCQA) or other national accrediting body as appropriate

VII. Scope

The QIP provides for the review and evaluation of all aspects of health care, encompassing both clinical care and service provided to external and internal customers. External and internal customers are defined as Members, practitioners, providers, employers, governmental agencies, and SCFHP employees.

All departments participate and collaborate in the quality improvement process. The CMO and the Director of Quality integrate the review and evaluation of components to demonstrate the process is effective in improving health care. The measurement of clinical and service outcomes and member satisfaction is used to monitor the effectiveness of the process.

A. The scope of quality review will be reflective of the health care delivery systems, including quality of clinical care and quality of service
B. All activities will reflect the member population in terms of age groups, disease categories and special risk status
C. The scope of the QI Program includes the monitoring and evaluation and driving improvements for key areas, including but not limited to the following:
    a. Access to Preventive Care (HEDIS)
    b. Behavioral Health Services
    c. Continuity and Coordination of Care
    d. Emergency Services
    e. Grievances

f. Inpatient Services
g. Maintenance of Chronic Care Conditions (HEDIS)
h. Member Experience and Satisfaction
i. Minor Consent/Sensitive Services
j. Perinatal Care
k. Potential Quality of Care Issues
l. Preventive Services for children and adults
m. Primary Care
n. Provider Satisfaction
o. Quality of Care Reviews
p. Specialty Care

D. Refer to the Utilization Management Program and the Case Management Program for QI activities related to the following:
   a. UM Metrics
   b. Prior authorization
   c. Concurrent review
   d. Retrospective review
   e. Referral process
   f. Medical Necessity Appeals
   g. Case Management
   h. Complex Case Management
   i. Disease Management
   j. California Children's Services (CCS)

VIII. QI Work Plan

The QI Program guides the development and implementation of an annual QI Work Plan that include:

A. Quality of clinical care
B. Quality of Service
C. Safety of clinical care
D. QI Program scope
E. Yearly objectives
F. Yearly planned activities
G. Time frame for each activity's completion
H. Staff responsible for each activity
I. Monitoring of previously identified issues
J. Annual evaluation of the QI Program
K. Priorities for QI activities based on the specific needs of SCFHP's organizational needs and specific needs of SCFHP's populations for key areas or issues identified as opportunities for improvement
L. Priorities for QI activities based on the specific needs of SCFHP's populations, and on areas identified as key opportunities for improvement

M. Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified (PQI)
N. The work plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures

There is a separate Utilization Management Work Plan that supports the UM Program Description and the monitoring and evaluation activities conducted for UM related functions.

IX. QI Methodology

SCFHP applies the principles of Continuous Quality Improvement (CQI) to all aspects of the service delivery system through ongoing analysis, evaluation and systematic enhancements based on:

A. Quantitative and qualitative data collection and data-driven decision-making.
B. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field.
C. Feedback provided by members and providers in the design, planning, and implementation of its CQI activities.
D. Rapid Cycle Quality Improvement, when appropriate, as determined by DHCS.
E. Issues identified by SCFHP, DHCS and/or CMS.
F. Ensure that the QI requirements of this contract are applied to the delivery of primary and specialty health care services, Behavioral Health services and LTSS.

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

A. Areas for improvement identified through continuous delegated and internal monitoring activities, including, but not limited to, (a) potential quality concern review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
B. Measures required by DHCS for Medi-Cal members such as Performance Improvement Projects (PIPs)
C. Measures required by the California DMHC, such as access and availability
D. Measures required by Centers for Medicare and Medicaid Services (CMS) such as Quality Improvement Activities (QIAs), Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), or Chronic Care Improvement Projects (CCIPs)

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, and ancillary care services

A. Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
B. Case Management
C. Coordination and continuity of care for Seniors and Persons with Disabilities

D. Provisions of complex care management services
E. Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

A. Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
B. Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
C. Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes
D. Project coordination occurs through the various leadership structures: Governing Board, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
E. These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Data Warehouse will be utilized.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 3 to 15% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on SFCHPs' previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

SCFHP uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement

2) Define baseline

3) Describe root cause(s)

4) Develop an action plan

Do 1) Communicate change/plan

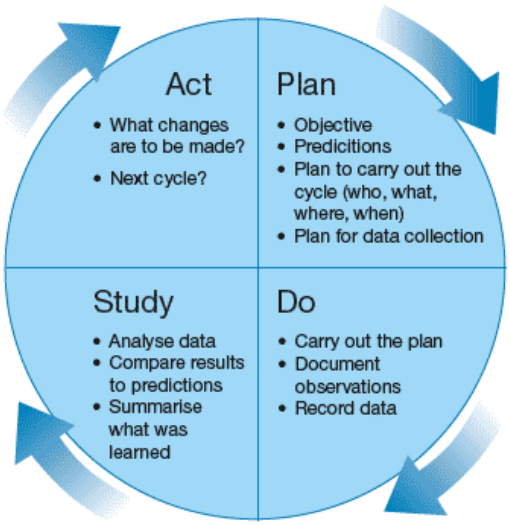
2) Implement change plan

Study 1) Review and evaluate result of change

2) Communicate progress

Act 1) Reflect and act on learning

2) Standardize process and celebrate success



X. QI Quality Issue Identification

SCFHP utilizes a full range of methods and tools of that program, including Adverse Event monitoring. An Adverse event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Adverse events can include:

A. Potential Quality Issues (PQI)
B. Unexpected death during hospitalization
C. Complications of care (outcomes), inpatient and outpatient
D. Reportable events for long-term care (LTC) facilities include but are not limited to falls, suspected abuse and/or neglect, medication errors, pressure sores, urinary tract infections, dehydration, pneumonia, and/or preventable hospital admissions from the LTC facilities
E. Reportable events for community-based adult services (CBAS) centers include but are not limited to falls, injuries, medication errors, wandering incidents, emergency room transfers, and deaths that occur in the CBAS center and unusual occurrences reportable pursuant to adult day health care licensing requirements.

Sentinel event monitoring includes patient safety monitoring across the entire continuum of SCFHP's contracted providers, delegated entities, and health care delivery organizations. The presence of a Sentinel event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as

possible. Sentinel event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All substantiated medically related cases are reviewed by the Credentialing and Peer Review Committee to determine the appropriate course of action and/or evaluate the actions recommended by delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to delegates for incorporation in their re-credentialing process.

Data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include, but are not limited to:

A. Claims information/activity
B. Encounter data
C. Utilization
D. Case Management
E. Pharmacy Data
F. Group Needs Assessments
G. Results of Risk Stratification
H. HEDIS Performance
I. Member and Provider Satisfaction
J. Quality Improvement Projects (QIPs)
K. Performance Improvement Projects (PIPs)
L. Chronic Care Improvement Projects (CCIPs)
M. Health Risk Assessment data
N. Consumer Assessment of Healthcare Providers & Systems (CAHPS)
O. Health Outcomes Survey (HOS)
P. Regulatory Reporting

Protocol for Using Quality Monitors Screens

Case Management and Utilization Management staff apply the quality monitor screens to each case reviewed during pre- certification and concurrent review. Contracted LTC facilities and CBAS centers must report all identified reportable events to the Director of Long Term Services and Supports. All potential quality issues are routed to the Quality Department. When it is decided that medical records are required, the Quality staff contacts the appropriate inpatient facility and ambulatory care site to obtain copies of the medical record. It may be necessary for a Quality staff member to visit the facility/site to review the record.

When a case is identified to have potential quality of care issues, the Quality Improvement Clinical Review staff will abstract the records and prepare the documents for review by the CMO or Medical Director.

The CMO or Medical Director reviews the case, assigns a priority level, initiates corrective action, or recommends corrective action as appropriate. For case of neglect or abuse, follow-up or corrective action may include referrals to Child or Adult Protective Services.

XI. QI Program Activities

The QI Program's scope includes implementation of QI activities or initiatives. The QIC and related committee and work groups select the activities that are designed to improve performance on selected high volume and/or high-risk aspects of clinical care and member service.

Prioritization

Certain aspects of clinical care and service data may identify opportunities to maximize the use of quality improvement resources. Priority will be given the following:

A. The annual analysis of member demographic and epidemiological data
B. Those aspects of care which occur most frequently or affect large numbers of members
C. Those diagnoses in which members are at risk for serious consequences or deprivation of substantial benefit if care does not meet community standards or is not medically indicated
D. Those processes involved in the delivery of care or service that, through process improvement interventions, could achieve a higher level of performance

Use of Committee Findings

To the degree possible, quality improvement systems are structured to recognize care for favorable outcomes as well as correcting instances of deficient practice. The vast majority of practicing physicians provides care resulting in favorable outcomes. Quality improvement systems explore methods to identify and recognize those treatment methodologies or protocols that consistently contribute to improved health outcomes. Information of such results is communicated to the Governing Board and providers on a regular basis. Written communication to primary practitioners is the responsibility of the Committee chairperson. Submission of written corrective action plans, as necessary, is required for the Committee's approval. Significant findings of quality improvement activities are incorporated into practitioner educational programs, the re-credentialing process, and the re-contracting process and personnel annual performance evaluations. All quality improvement activities are documented and the result of actions taken recorded to demonstrate the program's overall impact on improving health care and the delivery system.

Clinical Practice Guidelines

SCFHP utilizes evidence-based practice guidelines to establish requirements and measure performance on a minimum of three practice guidelines (chronic and behavioral health) annually to strive to reduce variability in clinical processes. Practice guidelines are developed with representation from the network practitioners. The guidelines are implemented after input from participating practitioners of the Clinical Quality Improvement, Utilization Management and Pharmacy and Therapeutics Committees. Guidelines will be reviewed and revised, as applicable, at least every two years.

Preventive Health/HEDIS Measures

The Quality Improvement Committee will determine aspects of care to be evaluated based on member population and regulatory requirements. At a minimum, HEDIS performance indicators will be monitored annually based on product type, i.e. Medi-Cal or CMC. Initiatives, such as for Pap smear education and compliance, are put in place to encourage member compliance with preventive care.

Disease Management Programs

The health care services staff, QIC and network practitioners identify members with, or at risk for, chronic medical conditions. The QIC is responsible for the development and implementation of disease management programs for identified conditions. Disease management programs are designed to support the practitioner- patient relationship and plan of care. The programs will emphasize the prevention of exacerbation and complications using evidence-based practice guidelines. The active disease management programs and their components will be identified in the annual CM work plan.

Complex case management and chronic care improvement are major components of the disease management program. Specific criteria are used to identify members appropriate for each component. Member self-referral and practitioner referral will be considered for entry into these programs.

Following confidentiality standards, eligible members are notified that they are enrolled in these programs, how they qualified, and how to opt-out if they desire. Case managers and care coordinators are assigned to specific members or groups of members and defined by stratification of the complexity of their condition and care required. The case managers'/care coordinators help members navigate the care system and obtain necessary services in the most optimal setting.

Continuity and Coordination of Care

The continuity and coordination of care that members receive is monitored across all practice and provider sites. As meaningful clinical issues relevant to the membership are identified, they will be addressed in the quality improvement work plan. The following areas are reviewed for potential clinical continuity and coordination of care concerns.

A. Primary care services
B. Behavioral health care services
C. Inpatient hospitalization services
D. Home health services
E. Skilled nursing facility services

The continuity and coordination of care received by members includes medical care in combination with behavioral health care. SCFHP collaborates with behavioral health practitioners to promote the following activities are accomplished:

A. Information Exchange – Information exchange between medical practitioners and behavioral health practitioners must be member-approved and be conducted in an effective, timely, and confidential manner.
B. Referral of Behavioral Health Disorders – Primary care practitioners are encouraged to make timely referral for treatment of behavioral health disorders commonly seen in their practices, i.e., depression.

C. Evaluation of Psychopharmacological Medication – Drug use evaluations are conducted to increase appropriate use, or decrease inappropriate use, and to reduce the incidence of adverse drug reactions.
D. Data Collection – Data is collected and analyzed to identify opportunities for improvement and collaborate with behavioral health practitioners for possible improvement actions.
E. Corrective Action – Collaborative interventions are implemented when opportunities for improvement are identified.

XII. QI Organizational Structure

Quality Improvement Department

The Department support and makes certain that processes and efforts of the organizational mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services that are members receive.

A. Monitor, evaluate and act on clinical outcomes for members
B. Conduct review and investigations for potential or actual Quality of Care matters
C. Conduct review and investigations for clinical grievances, including Potential Quality Issues (PQIs).
D. Design, manage and improve work processes, clinical, service, access, member safety, and quality related activities
    a. Drive improvement of quality of care received
    b. Minimize rework and costs
    c. Optimize the time involved in delivering patient care and service
    d. Empower staff to be more effective
    e. Coordinate and communicate organizational information, both division and department-specific, and system-wide
E. Support the maintenance of quality standards across the continuum of care and all lines of business
F. Maintain company-wide practices that support accreditation by the National Commission Quality Assurance (NCQA)

Chief Medical Officer

The CMO has an active and unrestricted license in the state of California. The CMO is responsible to report to the Governing Board at least quarterly on the Quality Improvement program including reports, outcomes, opportunities for improvement and corrective actions and communicating feedback from the Board to the committees as applicable. The CMO is responsible for day to day oversight and management of quality improvement, health care services and peer review activities. The CMO is also responsible for communicating information and updates regarding the QI Program to SCFHP leadership and staff via Staff meetings, executive team meetings, and other internal meetings.

Medical Director

The Medical Director(s) has an active unrestricted license in accordance with California state laws and regulations and serves as medical director to oversee and be responsible for the proper provision of core benefits and services to members, the quality improvement program, the utilization management program, and the grievance system. The Medical Directories key in the review of potential quality of care cases or potential quality issues.

The Medical Director(s) is required to supervise all medical necessity decisions and conducts medical necessity denial decisions, including resolving grievances related to medical quality of care. A Medical Director is the only Plan person authorized to make a clinical denial based on medical necessity. The Plan pharmacist(s) may make a denial based on medical necessity regarding pharmaceuticals.

Director of Quality

The Director of Quality is a licensed clinician or other qualified person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Director of Quality reports to the Chief Medical Director and is responsible for directing the activities of the Plan's quality improvement staff in monitoring and auditing the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Director of Quality assists the Plan's executive staff, both clinical and non-clinical, in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members. Additionally, the Director of Quality coordinates the Plan's QIC proceedings in conjunction with the CMO; report to the Board relevant QI activities and outcomes, support corporate initiatives through participation on committees and projects as requested; review statistical analysis of clinical, service and utilization data and recommend performance improvement initiatives while incorporating best practices as applicable.

Quality Improvement Manager

The Quality Improvement Manager provides leadership, coordination and is a person with experience in data analysis, barrier analysis, and project management as it relates improving the clinical quality of care and quality of service provided to Plan members. The Quality Improvement Manager reports to the Director of Quality and is responsible for managing the activities of the Plan's quality improvement staff in monitoring and auditing the Plan's health care delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. The Quality Improvement Manager assists the Director of Quality in overseeing the activities of the Plan operations to meet the Plan's goal of providing health care services that improve the health status and health outcomes of its members.

Process Improvement Manager

The Process Improvement Manager provides leadership, coordination and management as it relates to improving internal process related to quality of care and quality of service provided to Plan Members. The Process Improvement Manager reports to the Director of Quality is responsible for managing the Process Improvement team in reviewing the Plan's internal health care delivery systems, managing activities of the Plan's CAHPS and HOS surveys, Health Homes Program and NCQA accreditation.

QI Nurse, RN

The QI Nurse reports to the Quality Improvement Manager and oversees the investigations of member grievances, supports HEDIS medical record reviews, investigates and prepares cases for PQIs for the medical director or CMO review. The QI Nurse also assists with ongoing QI studies and reviews which include but are not limited to PIPs and CCIPs, as well as supports the Health Education Program with clinical perspective. The QI Nurse can also be a Master Trainer who oversees and coordinates facility site reviews, physical site reviews, medical record reviews, monitors compliance with Initial Health Assessments (IHAs), and assists with other QI activities at the direction of the Quality Improvement Manager.

QI Project Manager

The Quality Improvement Project Manager reports to the Process Improvement Manager and provides leadership, coordination, and management of QIPs, PIPs, CCIPs, CAHPS and HOS Surveys. In addition this this position is responsible for developing and maintaining processes that enhance the operationalization of Quality Improvement processes and support reporting requirements to DHCS, CMS and achieving SCFHP goals of improved quality of care and service.

HEDIS Project Manager

The HEDIS Project Manager provides coordination and project management of HEDIS and HEDIS- related quality improvement projects. This position is responsible for developing and maintaining processes that enhance the operationalization of HEDIS processes, management of software applications(s), and support reporting requirements to DHCS, CMS, NCQA and achieving SCFHP goals of improved quality of care and service.

Process Improvement Project Manager

The Process Improvement (PI) Project Manager provides coordination and project management of Plan process improvement projects. This position is responsible for The PI Project Manager is responsible for working collaboratively and cross-functionally with internal and external stakeholders, including consultants, auditors and surveyors to create efficiencies and quality improvements, as well as applying six sigma principals to processes at SCFHP.

Health Homes Program Manager

The Health Homes Program Manager provides coordination and program management of the Health Homes Program. This position is responsible for developing and maintaining processes related to the operationalization of Health Homes processes, supporting repot requirements to DHCS, and contracting with CB-CMEs to achieve a collaborative and effective program for Plan members.

Health Educator

The Health Educator is a Certified Health Education Specialist (CHES) responsible for coordinating, planning, organizing, implementing, monitoring and evaluating health education programs and cultural and linguistic services. The Health Educator is responsible for compliance to state and federal regulatory requirements concerning health education and cultural and linguistic services. The Health Educator

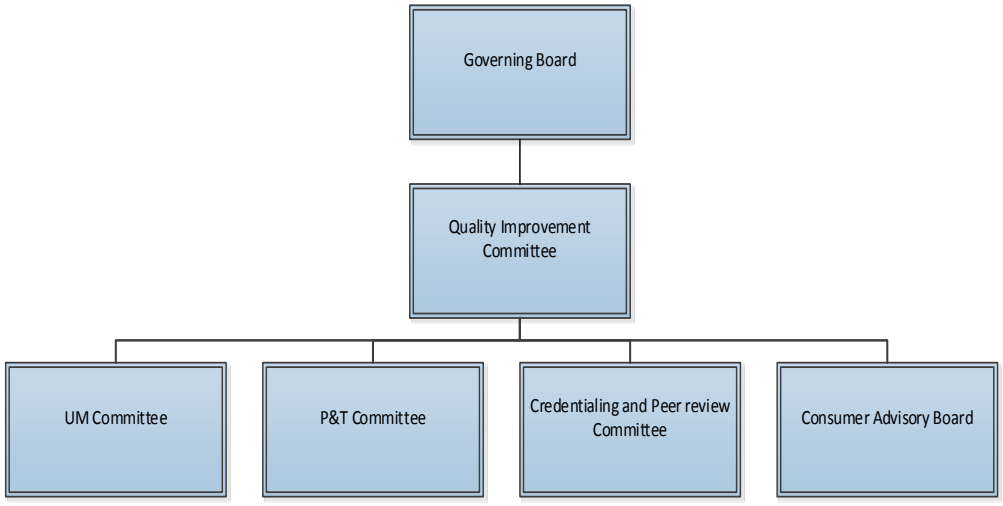
works under the general direction of the Quality Improvement Manager and works in cooperation with other departments.

Quality Improvement Coordinator

The QI Coordinator has experience in a health care setting; experience with data analysis and/or project management preferred. The QI Coordinator report to the Quality Improvement Manager and their scope of work may include medical record audits, data collection for various quality improvement studies and activities, data analysis and implementation of improvement activities and complaint response with follow up review of risk management and sentinel/adverse event issues. A QI Coordinator may specialize in one area of the quality process or may be cross trained across several areas. The QI Coordinator collaborates with other departments as needed to implement corrective action or improvement initiatives as identified through Plan's quality improvement activities and quality of care reviews.

XIII. Committee Structure Overview

Oversight of the Quality Improvement Program is provided through a committee structure, which allows for the flow of information to and from the Governing Board.



Each committee is driven by a Committee Charter which outlines the following;

A. Voting members
B. Plan support staff
C. Quorum
D. Meeting frequency
E. Meeting terms
F. Goals

G. Objectives

XIV. Committee Structure

Governing Board

The Governing Board is responsible to review, act upon and approve the overall QI Program, Work Plan, and Annual Evaluation. The Governing Board routinely received reports from the QIC describing actions taken, progress in meeting quality objectives and improvements made. The Board shall also make recommendations additional interventions and actions to be taken when objectives are not met.

The Director of Quality is responsible for the coordination and distribution of all quality improvement related data and information. The QIC reviews, analyzes, makes recommendations, initiates action, and/or recommends follow-up based on the data collected and presented. The CEO or the CMO communicates the QIC activities to the Board. The Board reviews the QI activities and any concerns of the Board are communicated back to the source for clarification or resolution.

Quality Improvement Committee

The QIC is the foundation of the QI program. The QIC assists the CMO and administration in overseeing, maintaining, and supporting the QI Program and Work Plan activities.

The purpose of the QIC is to monitor and assess that all QI activities are performed, integrated, and communicated internally and to the contracted network and partners to achieve the end result of improved care and services for members. Although Delegation Oversight is overseen by the Plan's Compliance Committee, the QIC oversees the performance of delegated functions and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates for activities that are consistent with SCFHP's strategic goals and priorities. It supports efforts for an interdisciplinary and interdepartmental approach and adequate resources for the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QI Projects), activities, and initiatives. In addition, and most importantly, it strives to ensure that members are provided the highest quality of care, adopt evidence based Clinical Practice Guidelines (CPG) and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations. HEDIS activities and interventions are reviewed, approved, processed, monitored, and reported through the QIC.

SCFHP involves a contracted network licensed behavioral specialist who is a psychiatrist or Ph.D. level psychologist to serve on the QIC and the UM Committee and as an advisor to the QI Program structure and processes. The designated behavioral health practitioner advises the QIC to support efforts that

goals, objectives and scope of the QI Program are interrelated in the process of monitoring the quality of behavioral health care, safety and services to members.

Providers', practitioners', and contracted groups practice patterns are evaluated, and recommendations are made to promote practices that all members receive medical care that meets SCFHP standards.

The QIC shall develop, oversee, and coordinate member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to SCFHP- contracted providers and practitioners, and contracted groups.

The QIC provides overall direction for the continuous improvement process and monitors that activities are consistent with SCFHP's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

In addition the Grievance/Appeals Committee conducts an analysis and intervention and reports to the QIC.

Utilization Management Committee

The Utilization Management Committee (UMC) promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary, and provides a comprehensive approach to support the Utilization Management Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC actively involves participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. Plan's UMC is comprised of network physicians representing the range of practitioners within the network and across the regions in which it operates, including a Behavioral Health practitioner. Plan executive leadership and Utilizaion Management/Quality Improvement staff may also attend the UMC as appropriate.

The UMC monitors the utilization of health care services by SCFHP and through delegated entities to identify areas of under- or over- utilization that may adversely impact member care as well as practice patterns of network practitioners and other QI monitors as defined by the Utilization Management Program and Utilization Management Work Plan.

The UMC oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, are evidence-based, and comply with regulatory and other agency standards.

The UMC is also responsible for annual adoption of preventive care guidelines and medical necessity criteria. The Committee meets quarterly and reports to the QIC.

The UMC is responsible for the review and adoption of applicable utilization management policies and procedures. Additionally, the UMC monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under - or over- utilization which may impact health care services, coordination of care and appropriate use of services and resources, continuity of medical to medical care, continuity and coordination of medical and behavioral health care, as well as member and practitioner satisfaction with the UM process.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is a forum for an evidence-based formulary review process. The P&T Committee promotes clinically sound and cost effective pharmaceutical care for all members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program.

In addition, the P&T Committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to SCFHP's members. The P&T Committee includes practicing physicians and the contracted provider networks, including both Plan employee physicians and participating provider physicians, and represents a cross section of clinical specialties including a Behavioral Health practitioner, in order to adequately represent the needs and interests of all plan members.

The P&T Committee involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacological drugs.

The P&T Committee also involves mental health prescribing practitioners in the development of the formulary for psycho-pharmacologic drugs and pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step-therapy.

The Committee provides written decisions regarding all formulary development and revisions. The P&T Committee meets at least quarterly, and reports to the QIC.

Credentialing and Peer Review Committee

Peer Review Committee is coordinated through the Credentialing. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases will be presented to the Credentialing and Peer Review Committee to assess if documentation is complete, and no further action is required. The QI Department also tracks, monitors, and trends service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the Credentialing and Peer Review Committee at time of re- credentialing. Quality of care case referral to the QI Department is based on referrals to the QI Department originated from multiple areas, which include, but are not limited to, the following: Prior Authorization, Concurrent Review, Case Management, Legal, Compliance, Customer Service, Pharmacy, or Grievances and Appeals Resolution.

XV. Role of Participating Practitioners

Participating practitioners, including a behavioral health practitioner who is either a medical doctor or PHD/PsyD, serve on the QI Program Committees as necessary to support each committee's function. Through these committees' activities, network practitioners:

A. Review, evaluate and make recommendations for credentialing and re-credentialing decisions
B. Review individual cases reflecting actual or potential adverse occurrences
C. Review and provide feedback on proposed medical guidelines, preventive health guidelines, clinical protocols, disease management programs, quality and HEDIS results, new technology and any other clinical issues regarding policies and procedures
D. Review proposed QI study designs
E. Participate in the development of action plans and interventions to improve levels of care and service
F. Are involved with policy setting
G. Participate with the following committees
    a. Quality Improvement Committee
    b. Pharmacy and Therapeutics Committee
    c. Utilization Management Committee
    d. Credentialing and Peer Review Committee
    e. Additional committees as requested by the Plan

XVI. Behavioral Health Services

SCFHP will monitor and improve the quality of behavioral health care and services provided through and based on applicable contract requirements. The QI program includes services for behavioral health and review of the quality and outcome of those services delivered to the members within our network of practitioners and providers. The quality of Behavioral Health services may be determined through, but not limited to the following:

A. Access to Care
B. Availability of practitioners
C. Coordination of care
D. Medical record and treatment record documentation
E. Complaints and grievances
F. Appeals
G. Utilization Metrics
    a. Timeliness
    b. Application of criteria
    c. Bed days
    d. Readmissions
    e. Emergency Department Utilization

f. Inter-rater reliability

H. Compliance with evidence-based clinical guidelines

I. Language assistance

Reporting to the CMO, the Director for Behavioral Health services shall be involved in the behavioral aspects of the QI Program. The Director shall be available for assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data, and follow-up on identified issues.

XVII. Utilization Management

Please refer to the Utilization Management Program Description for Utilization Management activities and related UM activities including Case Management, and Disease Management programs and processes.

XVIII. Care of Members with Complex Needs

Please refer to the Case Management program description and the Population Health Management Strategy document for complete details on care of members with complex SCFHP is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

A. Provide case management teams that focus on members who have had an organ transplant, with HIV/AIDS, progressive degenerative disorders and metastatic cancers.
B. Improve access to primary and specialty care to facilitate the receipt of appropriate services for members with complex health conditions
C. Coordinate care for members who receive multiple services.
D. Identify and reduce barrios to services for members with complex conditions.

XIX. Cultural and Linguistics

SCFHP will monitor that services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

SCFHP is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Identified needs and planned interventions involve member input and are vetted through the Customer Advisory Committee and Consumer Advisory Board prior to full implementation as determined by the plan's Health Educator.

All individuals providing linguistic services to SCFHP members shall be adequately proficient in the required language to both accurately convey and understand the information being communicated. This policy applies to SCFHP staff, providers, provider staff, and professional translators or interpreters. Monitoring of compliance ability to serve as an interpreter will be maintained by the Plan.

Interpreter services are provided to the member at no charge to the member.

SCFHP offers programs and services that are culturally and linguistically appropriate by:

A. Using practitioner and provider chart reviews and interviews to understand the differences in care provided and outcomes achieved to reduce health care disparities in clinical areas
B. Conducting patient-focused interventions with culturally competent outreach materials that focus on race, ethnicity and language specific risks to improve cultural competency in materials
C. Conducting focus groups or key informant interviews with cultural or linguistic minority members to determine how to better meet their needs to improve cultural competency communications as determined by the plan's Health Educator
D. Providing information, training and tools to staff and practitioners to support culturally competent communication to improve network adequacy to meet the needs of underserved groups.

SCFHP has designated the Director of Quality to provide oversight for meeting the objectives of service to a culturally and linguistically diverse population through the following:

A. Translation services
B. Interpretation services
C. Proficiency testing for bilingual staff
D. Cultural competency trainings such as:
    a. Cultural Competency annual online training for plan staff
E. Provider newsletter articles on a variety of cultural and linguistic issues
F. Health education materials in different languages and appropriate reading levels
G. Provider office signage on the availability of interpretation services

XX. Credentialing Processes

SCFHP conducts a Credentialing process that is in compliance withal regulatory and oversight requirements. SCFHP contracts with an NCQA Certified Vendor Organization (CVO). The Plan credentials all new applicants prior to executing a contract to see members and credentials network practitioners at least every 36 months.

The comprehensive credentialing process is designed to provide on-going verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status, and judgment, thus ensuring the competency of practitioners working within the SCFHP contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS, and NCQA). The scope of the credentialing program includes all licensed MDs, DOs, allied health and midlevel practitioners, which include, but are not limited to practitioners who work independently including behavioral health practitioners, Certified Nurse Midwives, Nurse Practitioners, Optometrist, etc., both in the delegated and direct contracts.

<u>Healthcare Delivery Organizations</u>

SCFHP performs credentialing and re-credentialing of ancillary providers and health care delivery organizations (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every 36 months thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies and as applicable, accreditation status.

Use of Quality Improvement Activities in the Re-credentialing Process

Findings from quality improvement activities are included in the Re-credentialing process. Should an egregious quality of care issue be identified mid-cycle, the Credentialing and Peer Review Committee may select to review the practitioner between routine re-credentialing cycles.

Monitoring for Sanctions and Complaints

SCFHP has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, state or federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns, and member complaints between re-credentialing periods.

XXI. Facility Site Review, Medical Record and Physical Accessibility Review

SCFHP does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted groups. SCFHP assumes responsibility and conducts and coordinates FSR/MRR in accordance with standards set forth by MMCD Policy Letter 14-004.

SCFHP collaborates with the entities to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs. Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 14-004 and SCFHP policies.

Medical records of new providers shall be reviewed within ninety (90) calendar days of the date on which members are first assigned to the provider. An additional extension of ninety (90) calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)

SCFHP conducts an additional DHCS-required facility audit for American with Disabilities Act for compliance of Seniors and Persons with Disabilities (SPD) members, which includes access evaluation criteria to determine compliance with ADA requirements.

Medical Record Documentation Standards

SCFHP requires that its contracted groups make certain that each member medical record is maintained in an accurate and timely manner that is current, detailed, organized, and easily accessible to treating practitioners. All member data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc.). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, and continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of the Plan's contracts with CMS and DHCS.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or state law.

XXII. Member Safety

The monitoring, assessment, analysis and promotion of member safety matters are integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part our quality and risk management functions. Our member safety efforts are clearly articulated both internally and externally, and include strategic efforts specific to member safety. The QI Program Description is based on a needs assessment, and includes the areas:

A. Identification and prioritization of patient safety-related risks for all SCFHP members, regardless of line of business and contracted health care delivery organizations
B. Operational objectives, roles and responsibilities, and targets based on the risk assessment
C. Plans to conduct appropriate patient safety training and education are available to members, families, and health care personnel/physicians
D. Health Education
E. Group Needs Assessment
F. Over- and Under- Utilization monitoring
G. Medication Management
H. Case Management and Disease Management outcomes
I. Operational Aspects of Care and Service

Member Safety prevention, monitoring and evaluation include:

A. Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
B. Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to ensure timely and accurate communication
C. Utilizing facility site review, Physical Accessibility Review Survey (PARS), and medical record review results from practitioner and healthcare delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act), and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process
D. Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff, and others in a variety of settings. The focus of the program is identifying and remediate potential and actual safety issues, and to monitor ongoing staff education.

A. Ambulatory setting
    a. Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    b. Annual blood-borne pathogen and hazardous material training
    c. Preventative maintenance contracts to promote that equipment is kept in good working order
    d. Fire, disaster, and evacuation plan, testing, and annual training
B. Institutional settings (including Long Term Care (LTC) and Long Term Support Services (LTSS) settings
    a. Falls and other prevention programs
    b. Identification and corrective action implemented to address post-operative complications
    c. Sentinel events identification and appropriate investigation and remedial action
    d. Administration of Flu/Pneumonia vaccine
C. Administrative offices
    a. Fire, disaster, and evacuation plan, testing, and annual training

XXIII. Member Experience and Satisfaction

SCFHP supports continuous ongoing measurement of clinical and non-clinical effectiveness and member satisfaction by monitoring member and provider complaints, member and provider satisfaction, and member and provider call center performance. The plan collects and analyzes data at least annually to measure its performance against established benchmarks or standards and identifies and prioritizes improvement opportunities. Specific interventions are developed and implemented to improve performance and the effectiveness of each intervention is measured at specific intervals, depending upon the intervention.

SCFHP solicits feedback from members, medical centers, and caregivers to assess satisfaction using a range of approaches, such as NCQA's Consumer Assessment of Healthcare Providers, HOS and member satisfaction survey, monitoring member complaints and direct feedback from grievances and appeals. The Quality Department is responsible for coordinating the HOS and CAHPS surveys, aggregating and analyzing the findings and reporting the results. Survey results are reviewed by the QIC with specific recommendations for performance improvement interventions or actions.

Provider satisfaction is assessed annually using valid survey methodology and a standardized comprehensive survey tool. The survey tool is designed to assess provider satisfaction with the network, claims, quality, utilization management, and other administrative services. Plan also uses another approach to obtain more real-time data related to new provider satisfaction.

Member Grievances and Provider Complaints

The QI Department investigates and resolves potential quality of care concerns and grievances. All grievances related to quality of care and service are tracked, classified according to severity, reviewed by Plan Medical Directors, categorized by the QI Department, and analyzed and reported on a routine basis to Plan's QIC. The QIC will recommend specific physician/provider improvement activities.

All administrative member grievances are tracked and resolution is facilitated by the Appeals and Grievance Coordinator. Data is analyzed and reported to the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Grievance reports are submitted to the QIC at least quarterly, along with recommendations for QI activities based on results.

Data is reported to and analyzed by the QIC on a regular basis to identify trends and to recommend performance improvement activities as appropriate. Provider complaint reports are submitted to the QI Committee at least quarterly, along with recommendations for QI activities based on results.

XXIV. Delegation Oversight

The Delegation Oversight process and Delegation Oversight Committee are reviewed through the Plan's Compliance Committee. The Delegation Committee reports to Compliance. The portion of Delegation Oversight specific to the QI Program are the reporting submitted by the delegated entities and the functional operational area overseeing corrective action plans.

Through Delegation Oversight, the Plan monitors include, but are not limited to, the following:

A. On-going monitoring via quarterly, semi-annual, and annual reports. Focus reviews are conducted when applicable
B. Annual site visits Annual Review of the delegates' policies and procedures
C. Annual review, feedback and approval of the delegates' Quality and Utilization Management Program Plans

D. Annual Review, approval, and feedback to the delegates on QI and utilization management work plans
E. Review and approval, by Compliance Committee, of sub-delegate's delegation agreement/s prior to implementation of such an agreement for sub-delegation
F. Sub-delegation reports
G. Review of case management program and processes Review of quality of care monitoring processes, results of QI Activities, and peer review processes
H. Review of credentialing and re-credentialing processes, working collaboratively with the delegates' staffs to review performance and develop strategies for improvement
I. Providing educational sessions
J. Evaluating and monitoring improvement
    a. Monthly and quarterly analysis of reports and utilization benchmarks by with results communicated to delegate, results reported on quarterly basis

The Plans' audit procedures drive the process with the delegates with the following:

A. Evaluation, oversight, and monitoring of the delegation agreement to determine what services can be delegated and how they can be delegated or not delegated
B. Providing input into contractual language necessary for delegation
C. Providing tools and designating appropriate measurement and reporting requirements for monitoring of delegated activities
D. Providing support in the analysis of data obtained from reporting and other oversight activities
E. Assisting in the development of corrective action plans and tracking of their effectiveness
F. Providing structure and methodology in the development and administration of incentives and sanction for delegate's performance.

When a delegate is determined to be deficient in an area or areas, the issue is referred to the Delegation Oversight Committee, which reports to the Compliance Committee, for its review and discussion, with recommendations to the Compliance Department for action.

The Compliance Department presents the issue to the Plan's Compliance Committee for decisions and final recommendations, which could include de-delegation.

XXV. Data Integrity/Analytics

The Clinical Data Warehouse aggregates data from SCFHP's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The data warehouse is maintained by the Information Systems (IS) Department. The data warehouse allows IS to provide analytic support to the QI Program. The data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures, and outcomes measures. SCFHP staff creates and maintains the data base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

A. Identify and stratify members with certain disease states
B. Identify over/under utilization of services
C. Identify missing preventive care services
D. Identify members for targeted interventions

Identification and Stratification of Members

Using clinical business rules, the database can identify members with a specific chronic disease condition, such as Asthma, Diabetes, Mental Health issues or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Potential of Over- and Under- Utilization of Services

Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days. Additional data will be available through UM Metrics such as hospital bed days, length of stays, Emergency Department utilization, readmissions, and UM referrals.

Identify Missing Preventive Care Services

The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50, or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions

The rules for identifying members and initiating the intervention are customizable to SCFHP to fit our unique needs. By using the standard clinical rules and customizing SCFHP specific rules, the database will be the primary conduit for targeting and prioritizing heath education, disease management, and HEDIS-related interventions.

By analyzing data that SCFHP currently receives (i.e. claims data, pharmacy data, and encounter data), the data warehouse will identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide SCFHP in not only targeting the members, but also the delegated entities, and providers who need additional assistance.

Medical Record Review

Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals will be utilized. Training for each data element (quality indicator) will be accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be coordinated by the Director of Quality or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, will be maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions

For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

A. Be clearly defined and outlined
B. Have specific objectives and timelines
C. Specify responsible departments and individuals
D. Be evaluated for effectiveness
E. Be tracked through the QI Program

For each project, there are specific system interventions that have a reasonable expectation of effecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring), and other plan-wide initiatives. In addition, provider and member specific interventions, such as reminder notices and informational communication, are developed and implemented.

Improvement Standards

A. Demonstrated Improvement
    a. Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.
B. Sustained Compliance with Improvement
    a. Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there is no other regulatory (CMS, DHCS, DMHC) reporting requirement related to that project. SCFHP may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects

Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

A. Project description, including relevance, literature review (as appropriate), source, and overall project goal.
B. Description of target population
C. Description of data sources and evaluation of their accuracy and completeness
D. Description of sampling methodology and methods for obtaining data
E. List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
F. Baseline data collection and analysis timelines
G. Data abstraction tools and guidelines
H. Documentation of training for chart abstraction
I. Rater to standard validation review results
J. Measurable objectives for each quality indicator
K. Description of all interventions including timelines and responsibility
L. Description of benchmarks
M. Re-measurement sampling, data sources, data collection, and analysis timelines
N. Evaluation of re-measurement performance on each quality indicator

Key Business Processes, Functions, Important Aspects of Care and Service

SCFHP provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community. The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the SCFHP model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.
- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include: Clinical Care and Service:

A. Access and Availability
B. Continuity and Coordination of Care
C. Preventive care, including:
    a. Initial Health Risk Assessment
    b. Behavioral Assessment
D. Patient Diagnosis, Care, and Treatment of acute and chronic conditions

E. Complex Case Management: SCFHP coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management Department, which details this process in its Utilization Management and Case Management Programs and other related policies and procedures.
F. Drug Utilization
G. Health Education
H. Over- and Under- Utilization monitoring
I. Disease Management Outcomes

Administrative Oversight:

A. Delegation Oversight
B. Member Rights and Responsibilities
C. Organizational Ethics
D. Effective Utilization of Resources
E. Management of Information
F. Financial Management
G. Management of Human Resources
H. Regulatory and Contract Compliance
I. Customer Satisfaction
J. Fraud and Abuse* as it relates to quality of care

* SCFHP has adopted a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the SCFHP Compliance Program.

XXVI. Conflict of Interest

Network practitioners serving on any QI Program related Committee, who are or were involved in the care of a member under review by the committee, are not allowed to participate in discussions and determinations regarding the case. Committee members cannot review cases involving family members, providers, or suppliers with whom they have a financial or contractual affiliation or other similar conflict of interest issues.

All employees and committee participants sign a Conflict of Interest statement on an annual basis.

Fiscal and clinical interests are separated. SCFHP and its delegates do not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care. There are no financial incentives for UM decision-makers that could encourage decisions that result in under-utilization.

XXVII. Confidentiality

SCFHP maintains policies and procedures to protect and promote the proper handling of confidential and privileged member information. Upon employment, all SCFHP employees, including contracted professionals who have access to confidential or member information, sign a written statement delineating responsibility for maintaining confidentiality.

In addition, all Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

All records and proceedings of the QIC and other QI Program related committees, which involve member- or practitioner-specific information are confidential, and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code section 14087.58, which exempts the records of QI proceedings from the California Public Records Act.

All information is maintained in confidential files. The medical groups hold all information in strictest confidence. Members of the QIC and the subcommittees sign a "Confidentiality Agreement." This Agreement requires the member to maintain confidentiality of any and all information discussed during the meeting.

XXVIII. Communication of QI Activities

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QIC quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Governing Board, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of SCFHP staff.

Communication of QI trends to SCFHP's contracted entities, members, practitioners and providers is through the following:

A. Practitioner participation in the QIC and its subcommittees
B. Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
C. Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on the Plan's website, in addition to the annual article in both practitioner and member newsletter.
D. The information to be shared with practitioners and members includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service.
E. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
F. Included in annual practitioner education through Provider Relations and the Provider Manual

XXIX. Annual Evaluation

The QIC conducts an annual written evaluation of the QI Program and makes information about the QI Program available to members and practitioners. Applicable QI related committees contribute to the annual evaluation which is ultimately reviewed and approved by the Governing Board.

The Plan conducts an annual written evaluation of the QI program and activities that include the following information

A. A description of completed and ongoing QI activities that address quality of care and safety of clinical care and quality of service
B. Trending of measures to assess performance in the quality and safety of clinical care and quality of services
C. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices
D. Barrier analysis

The evaluation addresses the overall effectiveness of the QI program, including progress that was made toward influencing network-wide safe clinical practices and includes assessment of:

A. The adequacy of QI Program resources
B. The QIC structure
C. Amount of Practitioner participation in the QI Program, policy setting, and review process
D. Leadership involvement in the QI Program and review process
E. Identification of needs to restructure or revise the QI Program for the subsequent year

Practitioners and members are advised of the availability of a summary of the QIP posted on the Plan's web site and that the summary is also available upon request. This summary includes information about the QIP's goals, processes, and outcomes as they relate to member care and service.

POLICY

Policy Title:	**Organizational Policies**	**Policy No.:**	GO.01 v2
Replaces Policy Title (if applicable):	Policy Development & Approval Process	**Replaces Policy No. (if applicable):**	CP001
Issuing Department:	Administration	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

I. Purpose

To provide guidance across Santa Clara Family Health Plan (SCFHP) in the development of policies to ensure a consistent approach and compliance with regulatory requirements and SCFHP's ~~the~~ approval process.

II. Policy

Policies are~~will be~~ developed as concise formal statements of principles that indicate how SCFHP will act in a particular aspect of its operation. Policies regulate and direct actions and conduct, and act as the business rules and guidelines under which the organization is operated. Policies are ~~will be~~ implemented in accordance with Procedures and supporting documents which provide instructions and set out processes to implement a Policy.

Policies and Procedures are ~~will be~~ created using templates approved by the Executive team. Policies are ~~and will be~~ approved as follows:

- First, by ~~by first~~ the departmental manager or director responsible for developing and implementing the policy;
- Second, by the Compliance Department to ensure regulatory requirements and citations are accurate; and
- Third, by the executive sponsor of the department. ~~second level approvers as defined in associated procedure(s).~~

III. Responsibilities

All department managers, directors and executives have responsibility to develop and approve policies in accordance with this policy.

IV. References

N/A

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
[Manager/Director Name] [Title] Date	[Compliance Name] Title] Date	[Executive Name] [Title] Date

Version Number	~~Change (~~Original/ Reviewed/ Revised~~)~~	Reviewing Committee (if applicable)	Committee Action/Date (Recommended or Approved)	Board Action/Date (Approved or Ratified)
V1	Original			Approved 4/28/16
V2	Revised			

POLICY

Policy Title:	**Organizational Policies**	**Policy No.:**	GO.01 v2
Replaces Policy Title (if applicable):	Policy Development & Approval Process	**Replaces Policy No. (if applicable):**	CP001
Issuing Department:	Administration	**Policy Review Frequency:**	Annual
Lines of Business (check all that apply):	☒ Medi-Cal	☒ Healthy Kids	☒ CMC

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IV. References

N/A

V. Approval/Revision History

First Level Approval	Second Level Approval	Third Level Approval
[Manager/Director Name] [Title] Date	[Compliance Name] Title] Date	[Executive Name] [Title] Date

Version Number	Original/ Reviewed/ Revised	Reviewing Committee (if applicable)	Committee Action/Date (Recommended or Approved)	Board Action/Date (Approved or Ratified)
V1	Original			Approved 4/28/16
V2	Revised			

Santa Clara Family Health Plan™

Unaudited Financial Statements
For The Seven Months Ended January 31, 2019

Agenda

Santa Clara Family Health Plan™

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Financial Highlights

Santa Clara Family Health Plan

	MTD		YTD	
Revenue	$82 M		$598 M	
Medical Expense (MLR)	$76 M	92.1%	$557 M	93.1%
Administrative Expense (% Rev)	$4.9 M	6.0%	$32.7 M	5.5%
Other Income/Expense	$331,434		$1,432,986	
Net Surplus (Loss)	**$1,880,961**		**$9,937,769**	
Cash on Hand			$206 M	
Receivables			$551 M	
Total Current Assets			$765 M	
Current Liabilities			$607 M	
Current Ratio			1.26	
Tangible Net Equity			$188 M	
% of DMHC Requirements			**538.8%**	

Financial Highlights

Santa Clara Family Health Plan

Net Surplus (Loss)	Month: Surplus of $1.9M is $1.3M or 249.1% favorable to budget of $0.5M. YTD: Surplus of $9.9M is $7.3M or 277.6% favorable to budget of $2.6M.
Enrollment	Month: Membership was 251,000 (-742 or -0.3% unfavorable budget of 251,742). YTD: Member months was 1.8M (1.2K or 0.1% favorable budget of 1.8M).
Revenue	Month: $82.1M ($1.3M or 1.7% favorable to budget of $80.7M) YTD: $598.1M ($31.9M or 5.6% favorable to budget of $566.3M)
Medical Expenses	Month: $75.6M (-$0.5M or -0.7% unfavorable to budget of $75.1M) YTD: $557.0M (-$27.3M or -5.2% unfavorable to budget of $529.6M)
Administrative Expenses	Month: $4.9M ($92.2K or 1.8% favorable to budget of $5.0M) YTD: $32.7M ($0.7M or 2.2% favorable to budget of $33.4M)
Tangible Net Equity	TNE was $188.0M (538.8% of minimum DMHC requirements of $34.9M)
Capital Expenditures	YTD Capital Investment of $5.3M vs. $11.3 annual budget was primarily due to building renovations.

Santa Clara Family Health Plan™

Detail Analyses

Enrollment

- Total enrollment has decreased since June 30, 2018 by 8,475 or -3.3%, in line with budget.
- As detailed on page 7, much of the Medi-Cal enrollment decline has been in the Medi-Cal Non-Dual Adult, Child, and Adult Expansion categories of aid. Medi-Cal Dual enrollment has been stable while CMC enrollment has grown due to outreach efforts.
- FY19 Membership Trends:
  - Medi-Cal membership has decreased since the beginning of the fiscal year by -3.5%. Over the past 12 months, enrollment has decreased 5.2%.
  - CMC membership increased since the beginning of the fiscal year by 3.3%. Over the past 12 months, enrollment has increased 4.9%.
  - Healthy Kids membership increased since the beginning of the fiscal year by 1.8%. Over the past 12 months, enrollment has increased 1.3%.

Santa Clara Family Health Plan Enrollment Summary

	For the Month of January 2019			For Seven Months Ending January 31 2019					
	Actual	Budget	Variance	Actual	Budget	Variance	Variance (%)	Prior Year Actuals	Δ FY18 vs. FY19
Medi-Cal	239,998	241,088	-(0.5%)	1,710,178	1,711,630	(1,452)	-(0.1%)	1,816,477	-(5.9%)
Cal Medi-Connect	7,750	7,715	0.5%	53,334	53,165	169	0.3%	51,766	3.0%
Healthy Kids	3,252	2,939	10.6%	22,902	20,408	2,494	12.2%	17,759	29.0%
Total	**251,000**	**251,742**	**-(0.3%)**	**1,786,414**	**1,785,203**	**1,211**	**0.1%**	**1,886,002**	**-(5.3%)**

Santa Clara Family Health Plan Enrollment By Network
January 2019

Network	Medi-Cal		CMC		Healthy Kids		Total	
	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total	Enrollment	% of Total
Direct Contract Physicians	29,917	12%	7,750	100%	382	12%	38,049	15%
SCVHHS[1], Safety Net Clinics, FQHC[2] Clinics	119,673	50%	-	0%	1,408	43%	121,081	48%
Palo Alto Medical Foundation	6,999	3%	-	0%	88	3%	7,087	3%
Physicians Medical Group	43,311	18%	-	0%	1,131	35%	44,442	18%
Premier Care	14,946	6%	-	0%	243	7%	15,189	6%
Kaiser	25,152	10%	-	0%	-	0%	25,152	10%
Total	**239,998**	**100%**	**7,750**	**100%**	**3,252**	**100%**	**251,000**	**100%**
Enrollment at June 30, 2018	248,776		7,503		3,196		259,475	
Net Δ from Beginning of FY19	-3.5%		3.3%		1.8%		-3.3%	

[1] *SCVHHS = Santa Clara Valley Health & Hospital System*
[2] *FQHC = Federally Qualified Health Center*

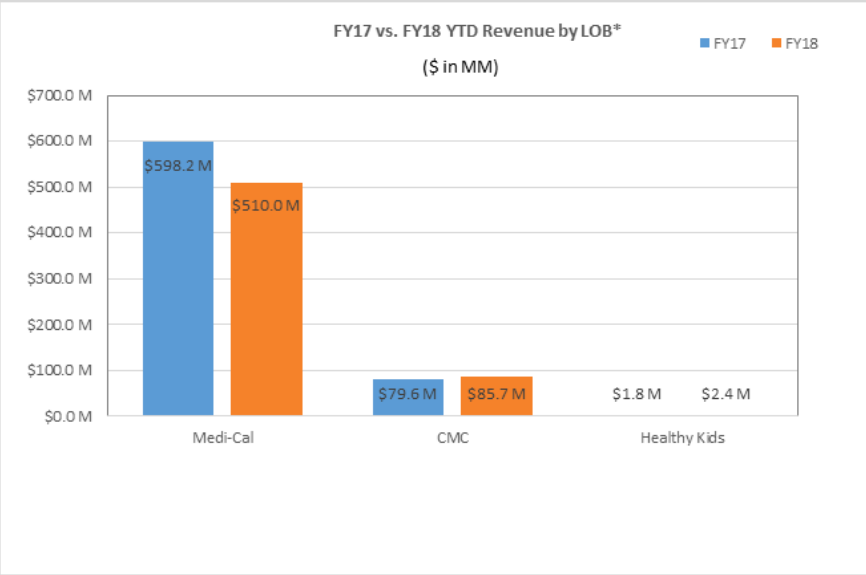
Enrollment By Aid Category

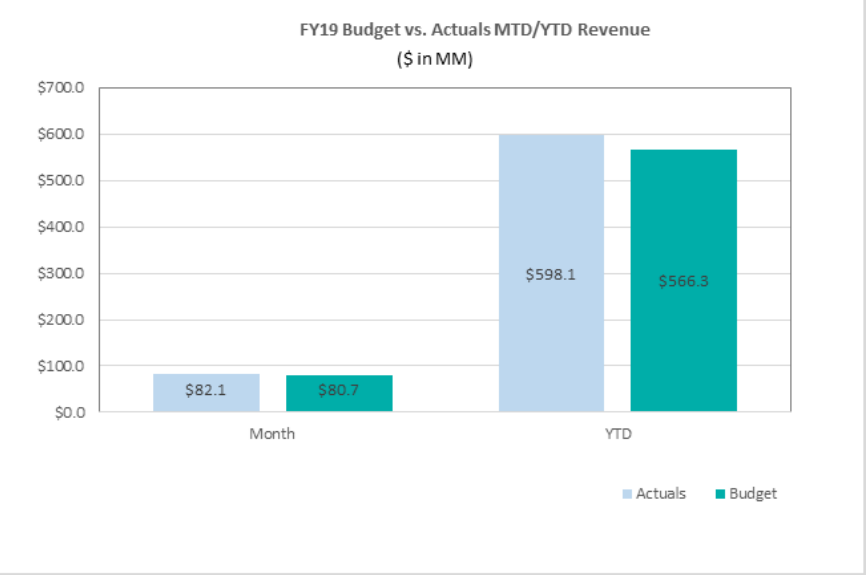
SCFHP TRENDED ENROLLMENT BY COA YTD JAN-19

		2017-06	2017-07	2017-08	2017-09	2017-10	2017-11	2017-12	2018-01	2018-02	2018-03	2018-04	2018-05	2018-06	2018-07	2018-08	2018-09	2018-10	2018-11	2018-12	2019-01
NON DUAL	Adult (over 19)	29,651	28,985	29,301	29,063	28,749	28,300	28,127	27,604	27,657	27,465	27,359	27,351	27,185	27,001	26,652	26,568	26,354	26,213	26,175	25,954
	Adult (under 19)	106,082	104,658	105,147	104,345	103,810	103,242	103,068	101,226	101,653	101,197	100,606	100,449	100,238	99,369	98,316	98,255	97,518	96,830	96,330	95,155
	Aged - Medi-Cal Only	10,674	10,776	10,693	10,722	10,801	10,778	10,781	10,892	10,906	10,906	10,924	10,891	10,963	10,909	10,815	10,887	10,869	10,887	10,923	10,901
	Disabled - Medi-Cal Only	10,979	10,965	10,903	10,888	10,880	10,875	10,843	10,807	10,825	10,786	10,801	10,750	10,750	10,742	10,679	10,635	10,611	10,624	10,631	10,629
	Adult Expansion	82,349	80,300	80,741	80,470	79,998	79,232	79,207	76,923	77,302	76,985	76,677	74,319	74,292	74,261	73,971	73,959	73,601	73,398	73,186	72,075
	BCCTP	18	17	17	17	17	16	16	15	15	15	15	15	13	13	14	13	12	11	11	9
	Long Term Care	488	382	373	375	396	411	396	385	370	353	358	370	384	382	384	387	379	377	372	371
	Total Non-Duals	**240,241**	**236,083**	**237,175**	**235,880**	**234,651**	**232,854**	**232,438**	**227,852**	**228,728**	**227,707**	**226,740**	**224,145**	**223,824**	**222,676**	**220,831**	**220,703**	**219,343**	**218,340**	**217,628**	**215,093**
DUAL	Adult (21 Over)	463	464	450	447	444	427	433	421	419	416	401	397	393	387	385	382	385	390	379	373
	Aged (21 Over)																				
	Disabled (21 Over)	23,010	22,906	23,299	23,412	23,452	23,433	23,331	23,300	23,405	23,312	22,969	23,064	22,811	22,919	22,928	22,984	22,963	22,897	22,893	22,765
	Adult Expansion	906	806	784	793	789	717	709	474	433	470	451	421	451	455	485	521	533	538	586	556
	BCCTP	1	1	1	1				1	1	2	2	2	2	2	2	2	1	1	1	2
	Long Term Care	1,132	1,131	1,162	1,169	1,182	1,202	1,195	1,209	1,155	1,118	1,117	1,159	1,295	1,316	1,323	1,292	1,268	1,233	1,208	1,209
	Total Duals	**25,512**	**25,308**	**25,696**	**25,822**	**25,867**	**25,779**	**25,668**	**25,405**	**25,413**	**25,318**	**24,940**	**25,043**	**24,952**	**25,079**	**25,123**	**25,181**	**25,150**	**25,059**	**25,067**	**24,905**
	Total Medi-Cal	**265,753**	**261,391**	**262,871**	**261,702**	**260,518**	**258,633**	**258,106**	**253,257**	**254,141**	**253,025**	**251,680**	**249,188**	**248,776**	**247,755**	**245,954**	**245,884**	**244,493**	**243,399**	**242,695**	**239,998**
	Healthy Kids	**2,732**	**2,633**	**2,618**	**2,243**	**2,288**	**2,321**	**2,447**	**3,209**	**3,250**	**3,415**	**3,454**	**3,220**	**3,196**	**3,278**	**3,187**	**3,163**	**3,217**	**3,460**	**3,345**	**3,252**
CMC	CMC Non-Long Term Care	7,260	7,250	7,138	7,122	7,067	7,093	7,128	7,132	7,162	7,153	7,194	7,203	7,275	7,302	7,318	7,386	7,383	7,407	7,484	7,540
	CMC - Long Term Care	283	275	267	261	259	256	261	257	255	256	241	237	228	221	222	214	218	218	211	210
	Total CMC	**7,543**	**7,525**	**7,405**	**7,383**	**7,326**	**7,349**	**7,389**	**7,389**	**7,417**	**7,409**	**7,435**	**7,440**	**7,503**	**7,523**	**7,540**	**7,600**	**7,601**	**7,625**	**7,695**	**7,750**
	Total Enrollment	**276,028**	**271,549**	**272,894**	**271,328**	**270,132**	**268,303**	**267,942**	**263,855**	**264,808**	**263,849**	**262,569**	**259,848**	**259,475**	**258,556**	**256,681**	**256,647**	**255,311**	**254,484**	**253,735**	**251,000**

Revenue

- Current month revenue of $82.1M is $1.3M or 1.7% favorable to budget of $80.7M. YTD revenue of $598.1M is $31.9M or 5.6% favorable to budget of $566.3M. This month's variances were due to several factors including:
  - Updated FY19 Prop 56 accrual increased revenue by $1.8M (with offsetting increase to medical expense).
  - Hep C revenue was up in January to $0.7M and favorable to budget by $0.3M.
  - Other fluctuations are due to the mix within the Medi-Cal categories of aid and updated rate accruals.





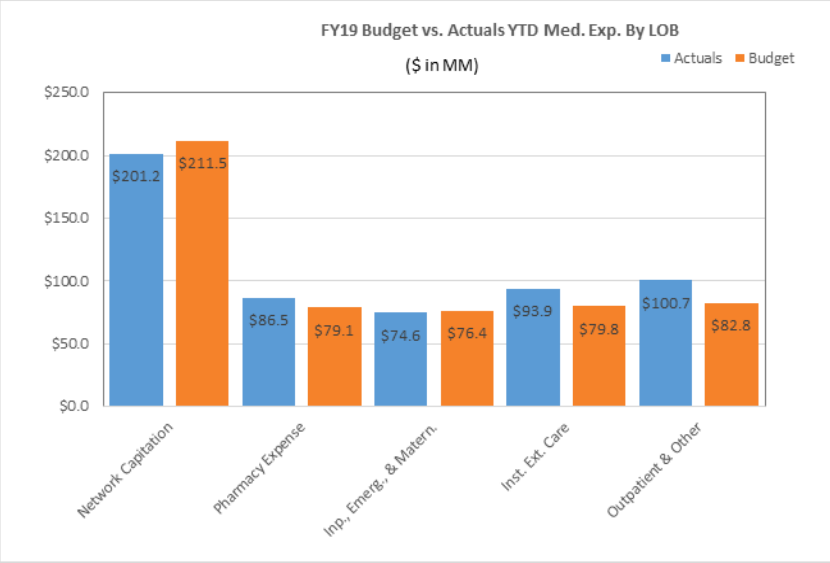
	FY17 vs. FY18 YTD Revenue by LOB*			
	FY17	FY18	Variance	
Medi-Cal	$598.2 M	$510.0 M	($88.1 M)	-14.7%
CMC	$79.6 M	$85.7 M	$6.1 M	7.6%
Healthy Kids	$1.8 M	$2.4 M	$0.6 M	33.8%
Total Revenue	**$679.6 M**	**$598.1 M**	**($75.4 M)**	**-11.1%**

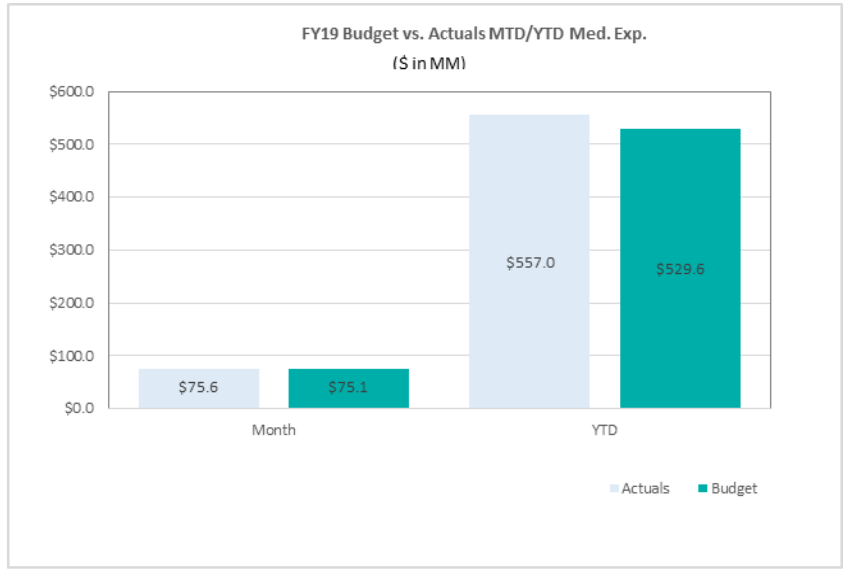
	FY19 Budget vs. Actuals MTD/YTD Revenue			
	Actuals	Budget	Variance	
Month	$82.1	$80.7	$1.3	1.7%
YTD	$598.1	$566.3	$31.9	5.6%

*IHSS was included in FY18 revenue through 12/31/17

Medical Expense

- Current month medical expense of $75.6M is $0.5M or 0.7% unfavorable to budget of $75.1M. YTD medical expense of $557.0M is $27.3M or 5.2% unfavorable to budget of $529.6M.The current month variances were due to a variety of factors, including:
  - Increased Inpatient, Outpatient and LTC expenses yielded an unfavorable variance of $5.0M.
  - Pharmacy costs exceeded budget by $2.4M due to increased utilization, higher specialty drug costs and increased branded usage.
  - Updated FY19 Prop 56 accrual increased expense by $1.8M (with offsetting increase to revenue).
  - Largely offsetting the above items, capitation expense was under budget by $8M due to retroactive claw-backs.





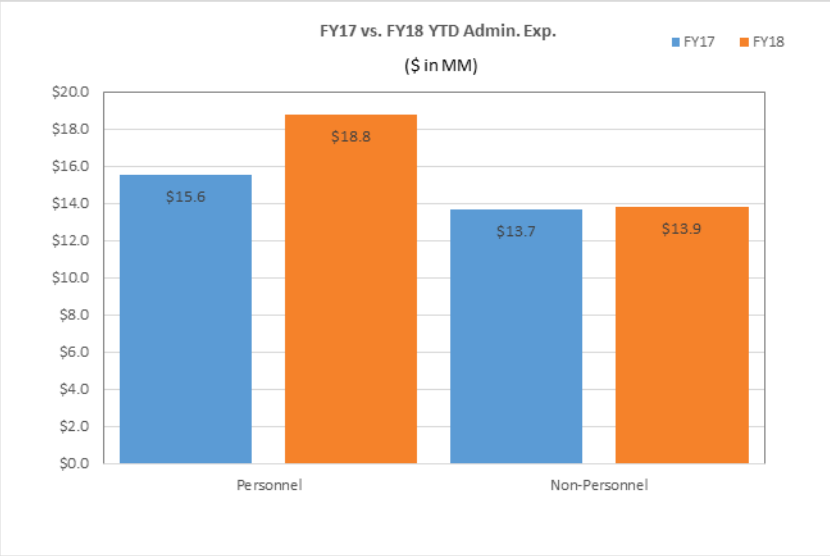
	FY19 Budget vs. Actuals YTD Med. Exp. By LOB			
	Actuals	Budget	Variance	
Network Capitation	$201.2	$211.5	$10.2	5.1%
Pharmacy	$86.5	$79.1	-$7.4	-8.6%
Inp., Emerg., & Matern.	$74.6	$76.4	$1.8	2.4%
Inst. Ext. Care	$93.9	$79.8	-$14.0	-15.0%
Outpatient & Other	$100.7	$82.8	-$17.9	-17.8%
Total Medical Expense	**$557.0**	**$529.6**	**-$27.3**	**-4.9%**

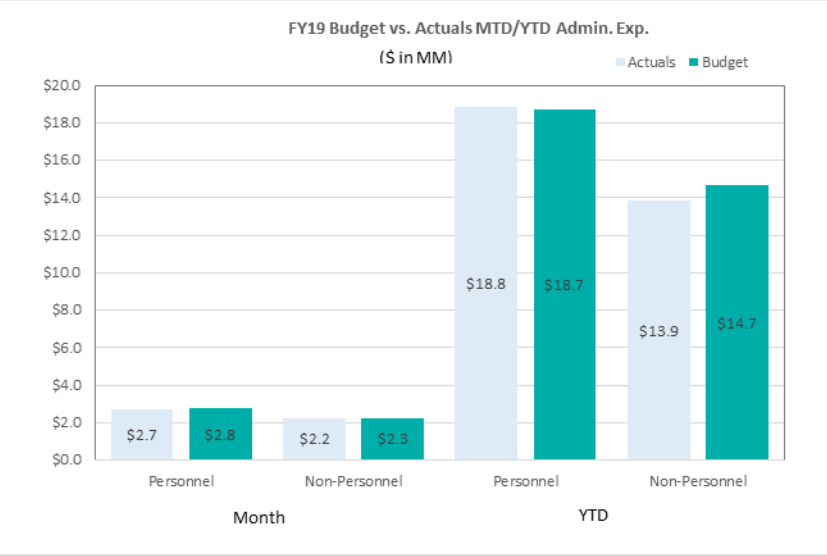
	FY19 Budget vs. Actuals MTD/YTD Med. Exp.			
	Actuals	Budget	Variance	
Month	$75.6	$75.1	$0.5	0.7%
YTD	$557.0	$529.6	$27.3	5.2%

**IHSS was included in medical expense through 12/31/17*

Administrative Expense

- Current month admin expense of $4.9M is $92.2K or 1.8% favorable to budget of $5.0M. YTD admin expense of $32.7M is $0.7M or 2.2% favorable to budget of $33.4M. The current month variances were due to a variety of factors, including:
  - Personnel expenses were 0.5% over budget due to the timing of hiring staff.
  - Consultants and temp staff expense have seen an increase due largely to recent audits by $590K.
  - Printing and postage are favorable to the YTD budget by $467K due to the timing of expenses.





	FY17 vs. FY18 YTD Admin. Exp.			
	FY17	FY18	Variance	
Personnel	$15.6	$18.8	$3.2	20.7%
Non-Personnel	$13.7	$13.9	$0.1	1.0%
Total Administrative Expense	**$29.3**	**$32.7**	**$3.4**	**11.5%**

		FY19 Budget vs. Actuals MTD/YTD Admin. Exp.			
		Actuals	Budget	Variance	
Month	Personnel	$2.7	$2.8	-$0.1	-2.0%
	Non-Personnel	$2.2	$2.3	$0.0	-1.6%
	MTD Total	**$4.9**	**$5.0**	**-$0.1**	**-1.8%**
YTD	Personnel	$18.8	$18.7	$0.1	0.5%
	Non-Personnel	$13.9	$14.7	-$0.8	-5.5%
	YTD Total	**$32.7**	**$33.4**	**-$0.7**	**-2.2%**

Balance Sheet

- Current assets totaled $765.4M compared to current liabilities of $607.1M, yielding a current ratio (Current Assets/Current Liabilities) of 1.26:1 vs. the DMHC minimum requirement of 1.0:1.
- Cash as of January 31, 2019 decreased by -$18.1M compared to the cash balance as of year-end June 30, 2018.
- Current Cash & Equivalent components and yields were as follows:

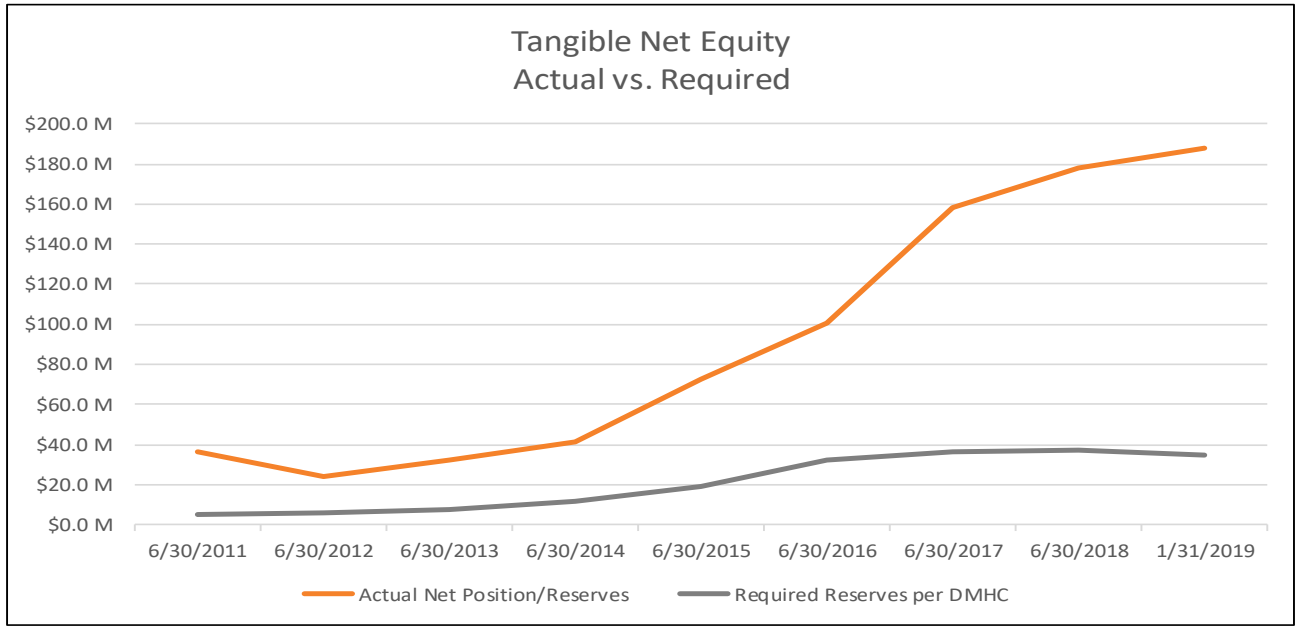
Description	Month-End Balance	Current Yield %	Interest Earned	
			Month	YTD
Short-Term Investments				
County of Santa Clara Comingled Pool	$78,154,867	1.95%	$210,571	$810,571
Cash & Equivalents				
Bank of the West Money Market	$231,585	1.34%	$3,531	$54,159
Wells Fargo Bank Accounts	$127,341,691	2.27%	$234,318	$1,505,126
	$127,573,276		$237,850	$1,559,285
Assets Pledged to DMHC				
Restricted Cash	$305,350	0.42%	$259	$322
Petty Cash	$500	0.00%	$0	$0
Total Cash & Equivalents	**$206,033,993**		**$448,679**	**$2,370,178**

Tangible Net Equity

- TNE was $188.0M in January 2019 or 538.8% of the most recent quarterly DMHC minimum requirement of $34.9M. TNE trends for SCFHP are shown below.

Santa Clara Health Authority
Tangible Net Equity - Actual vs. Required
As of: January 31, 2019

	6/30/2011	6/30/2012	6/30/2013	6/30/2014	6/30/2015	6/30/2016	6/30/2017	6/30/2018	1/31/2019
Actual Net Position/Reserves	$36.1 M	$24.2 M	$32.6 M	$40.9 M	$72.6 M	$100.3 M	$158.4 M	$178.0 M	$188.0 M
Required Reserves per DMHC	$5.0 M	$5.9 M	$7.8 M	$11.4 M	$19.3 M	$32.4 M	$35.9 M	$36.8 M	$34.9 M
200% of Required Reserve	$10.0 M	$11.8 M	$15.6 M	$22.9 M	$38.5 M	$64.8 M	$71.8 M	$73.6 M	$69.8 M
Actual as % Required	722.5%	410.2%	418.5%	357.5%	376.9%	309.8%	441.2%	483.4%	538.8%



Reserves Analysis

SCFHP RESERVES ANALYSIS January 2019	
Financial Reserve Target #1: Tangible Net Equity	
Actual TNE	187,953,632
Current Required TNE	34,885,779
Excess TNE	**153,067,853**
Required TNE %	538.8%
SCFHP Target TNE Range:	
350% of Required TNE (Low)	122,100,227
500% of Required TNE (High)	174,428,896
TNE Above/(Below) SCFHP Low Target	**$65,853,405**
TNE Above/(Below) High Target	**$13,524,736**
Financial Reserve Target #2: Liquidity	
Cash & Cash Equivalents	206,033,993
Less Pass-Through Liabilities	
Other Pass-Through Liabilities	(15,583,165)
Total Pass-Through Liabilities	**(15,583,165)**
Net Cash Available to SCFHP	$190,450,827
SCFHP Target Liability	
45 Days of Total Operating Expense	(120,210,934)
60 Days of Total Operating Expense	(160,281,245)
Liquidity Above/(Below) SCFHP Low Target	**$70,239,893**
Liquidity Above/(Below) High Target	**$30,169,582**

In December 2018, the Governing Board established a Board Discretionary Fund of $2.2M. The specific projects/recipients have yet to be determined.

Capital Expenditures

- YTD Capital investments of $5M, largely to complete the renovation of the new building, were comprised of the following:

Expenditure	YTD Actual	Annual Budget	
Building	$4,852,056	$ 7,874,631	*
Systems	0	925,000	
Hardware	134,415	1,550,000	
Software	277,000	593,000	
Furniture and Fixtures	0	0	
Automobile	0	0	
Leasehold Improvements	0	0	
TOTAL	**$5,263,470**	**$10,942,631**	

** Includes FY18 budget rollover of $6,628,131*

Santa Clara Family Health Plan™

Financial Statements

Income Statement

Santa Clara Family Health Plan

Santa Clara County Health Authority
Income Statement for Seven Months Ending January 31, 2019

	Current Month						Fiscal Year To Date					
	Actuals	% of Rev	Budget	% of Rev	Variance	% Var	Actuals	% of Rev	Budget	% of Rev	Variance	% Var
REVENUE												
MEDI-CAL	$ 69,130,757	84.2%	$ 68,097,959	84.4%	$ 1,032,798	1.5%	$ 510,034,471	85.3%	$ 481,064,749	85.0%	$ 28,969,723	6.0%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	2,361,910	2.9%	2,543,580	3.2%	(181,670)	-7.1%	16,653,066	2.8%	17,528,117	3.1%	(875,052)	-5.0%
CMC MEDICARE	10,205,489	12.4%	9,777,088	12.1%	428,401	4.4%	68,997,526	11.5%	65,568,527	11.6%	3,428,999	5.2%
TOTAL CMC	12,567,399	15.3%	12,320,668	15.3%	246,731	2.0%	85,650,592	14.3%	83,096,644	14.7%	2,553,948	3.1%
HEALTHY KIDS	357,885	0.4%	305,362	0.4%	52,523	17.2%	2,449,690	0.4%	2,120,391	0.4%	329,299	15.5%
TOTAL REVENUE	**$ 82,056,041**	**100.0%**	**$ 80,723,989**	**100.0%**	**$ 1,332,052**	**1.7%**	**$ 598,134,753**	**100.0%**	**$ 566,281,784**	**100.0%**	**$ 31,852,969**	**5.6%**
MEDICAL EXPENSE												
MEDI-CAL	$ 63,586,078	77.5%	$ 63,432,311	78.6%	$ (153,767)	-0.2%	$ 470,773,521	78.7%	$ 449,536,808	79.4%	$ (21,236,714)	-4.7%
CAL MEDI-CONNECT:												
CMC MEDI-CAL	*2,773,765*	*3.4%*	*2,230,889*	*2.8%*	*(542,876)*	*-24.3%*	*17,650,417*	*3.0%*	*15,373,329*	*2.7%*	*(2,277,088)*	*-14.8%*
CMC MEDICARE	*8,952,842*	*10.9%*	*9,119,790*	*11.3%*	*166,948*	*1.8%*	*66,286,189*	*11.1%*	*62,827,432*	*11.1%*	*(3,458,757)*	*-5.5%*
TOTAL CMC	11,726,608	14.3%	11,350,679	14.1%	(375,928)	-3.3%	83,936,605	14.0%	78,200,761	13.8%	(5,735,845)	-7.3%
HEALTHY KIDS	246,141	0.3%	275,029	0.3%	28,888	10.5%	2,246,125	0.4%	1,909,765	0.3%	(336,361)	-17.6%
TOTAL MEDICAL EXPENSES	**$ 75,558,826**	**92.1%**	**$ 75,058,019**	**93.0%**	**$ (500,807)**	**-0.7%**	**$ 556,956,252**	**93.1%**	**$ 529,647,333**	**93.5%**	**$ (27,308,919)**	**-5.2%**
MEDICAL OPERATING MARGIN	**$ 6,497,214**	**7.9%**	**$ 5,665,969**	**7.0%**	**$ 831,245**	**62.4%**	**$ 41,178,501**	**6.9%**	**$ 36,634,451**	**6.5%**	**$ 4,544,051**	**14.3%**
ADMINISTRATIVE EXPENSE												
SALARIES AND BENEFITS	$ 2,733,284	3.3%	$ 2,789,833	3.5%	$ 56,549	2.0%	$ 18,823,171	3.1%	$ 18,732,325	3.3%	$ (90,846)	-0.5%
RENTS AND UTILITIES	46,470	0.1%	17,611	0.0%	(28,859)	-163.9%	331,598	0.1%	364,837	0.1%	33,240	9.1%
PRINTING AND ADVERTISING	25,711	0.0%	493,150	0.6%	467,439	94.8%	542,749	0.1%	1,026,050	0.2%	483,301	47.1%
INFORMATION SYSTEMS	188,301	0.2%	226,473	0.3%	38,172	16.9%	1,294,661	0.2%	1,585,312	0.3%	290,650	18.3%
PROF FEES/CONSULTING/TEMP STAFFING	1,432,215	1.7%	842,649	1.0%	(589,566)	-70.0%	7,714,027	1.3%	6,342,587	1.1%	(1,371,441)	-21.6%
DEPRECIATION/INSURANCE/EQUIPMENT	364,271	0.4%	469,566	0.6%	105,295	22.4%	2,576,449	0.4%	3,243,464	0.6%	667,016	20.6%
OFFICE SUPPLIES/POSTAGE/TELEPHONE	64,102	0.1%	74,330	0.1%	10,228	13.8%	601,415	0.1%	1,148,252	0.2%	546,837	47.6%
MEETINGS/TRAVEL/DUES	77,286	0.1%	108,506	0.1%	31,220	28.8%	602,745	0.1%	755,640	0.1%	152,896	20.2%
OTHER	16,048	0.0%	17,804	0.0%	1,756	9.9%	186,903	0.0%	194,211	0.0%	7,308	3.8%
TOTAL ADMINISTRATIVE EXPENSES	**$ 4,947,688**	**6.0%**	**$ 5,039,923**	**6.2%**	**$ 92,235**	**1.8%**	**$ 32,673,718**	**5.5%**	**$ 33,392,679**	**5.9%**	**$ 718,961**	**2.2%**
OPERATING SURPLUS (LOSS)	$ 1,549,526	1.9%	$ 626,047	0.8%	$ 923,480	147.5%	$ 8,504,784	1.4%	$ 3,241,772	0.6%	$ 5,263,012	162.3%
OTHER INCOME/EXPENSE												
GASB 45 - POST EMPLOYMENT BENEFITS EXPENSE	(59,780)	-0.1%	(59,780)	-0.1%	0	0.0%	(418,458)	-0.1%	(418,460)	-0.1%	2	0.0%
GASB 68 - UNFUNDED PENSION LIABILITY	(75,000)	-0.1%	(75,000)	-0.1%	-	0.0%	(525,000)	-0.1%	(525,000)	-0.1%	-	0.0%
INTEREST & OTHER INCOME	466,214	0.6%	47,605	0.1%	418,609	879.3%	2,376,444	0.4%	333,235	0.1%	2,043,209	613.1%
OTHER INCOME/EXPENSE	**331,434**	**0.4%**	**(87,175)**	**-0.1%**	**418,609**	**-480.2%**	**1,432,986**	**0.2%**	**(610,225)**	**-0.1%**	**2,043,211**	**-334.8%**
NET SURPLUS (LOSS)	**$ 1,880,961**	**2.3%**	**$ 538,872**	**0.7%**	**$ 1,342,089**	**249.1%**	**$ 9,937,769**	**1.7%**	**$ 2,631,547**	**0.5%**	**$ 7,306,223**	**277.6%**

Balance Sheet

Santa Clara Family Health Plan™

Assets	January 2019	December 2018	November 2018	June 2018
Current Assets				
Cash and Marketable Securities	$206,033,993	$208,026,081	$219,146,700	$224,156,209
Receivables	550,751,893	534,641,224	516,509,111	493,307,425
Prepaid Expenses and Other Current Assets	8,648,220	8,623,739	8,790,259	7,024,982
Total Current Assets	**765,434,106**	**751,291,045**	**744,446,070**	**724,488,615**
Long Term Assets				
Property and Equipment	43,842,601	43,554,399	43,080,423	38,579,130
Accumulated Depreciation	(16,511,470)	(16,186,309)	(15,859,845)	(14,309,761)
Total Long Term Assets	27,331,131	27,368,090	27,220,578	24,269,369
Total Assets	**792,765,237**	**778,659,134**	**771,666,648**	**748,757,984**
Deferred Outflow of Resources	**14,535,240**	**14,535,240**	**14,535,240**	**14,535,240**
Total Deferred Outflows and Assets	**807,300,477**	**793,194,374**	**786,201,888**	**763,293,224**
Liabilities and Net Assets				
Current Liabilities				
Trade Payables	4,494,896	3,986,497	8,265,592	8,351,090
Deferred Rent	(0)	(0)	(0)	17,011
Employee Benefits	1,686,776	1,725,742	1,668,438	1,473,524
Retirement Obligation per GASB 45	3,969,253	3,909,473	5,181,693	4,882,795
Advance Premium - Healthy Kids	87,512	78,886	82,523	66,195
Deferred Revenue - Medicare	-	-	8,943,810	9,928,268
Whole Person Care/Prop 56	15,583,165	13,847,960	12,063,420	9,263,004
Payable to Hospitals	-	-	-	0
Due to Santa Clara County Valley Health Plan and Kaiser	12,593,341	10,370,443	9,163,650	6,691,979
MCO Tax Payable - State Board of Equalization	8,784,630	26,353,890	17,569,260	(0)
Due to DHCS	57,457,558	35,038,446	30,744,662	24,429,978
Liability for In Home Support Services (IHSS)	416,092,527	413,549,552	413,549,552	413,549,551
Current Premium Deficiency Reserve (PDR)	2,374,525	2,374,525	2,374,525	2,374,525
Medical Cost Reserves	83,918,726	83,657,353	86,276,451	92,470,504
Total Current Liabilities	**607,042,908**	**594,892,767**	**595,883,575**	**573,498,425**
Non-Current Liabilities				
Noncurrent Premium Deficiency Reserve (PDR)	5,919,500	5,919,500	5,919,500	5,919,500
Net Pension Liability GASB 68	2,349,796	2,274,796	2,199,796	1,824,796
Total Non-Current Liabilities	**8,269,296**	**8,194,296**	**8,119,296**	**7,744,296**
Total Liabilities	**615,312,204**	**603,087,063**	**604,002,871**	**581,242,721**
Deferred Inflow of Resources	**4,034,640**	**4,034,640**	**4,034,640**	**4,034,640**
Net Assets / Reserves				
Invested in Capital Assets	27,331,131	27,368,090	27,220,578	24,269,369
Restricted under Knox-Keene agreement	305,350	305,350	305,350	305,350
Unrestricted Net Equity	150,379,382	150,342,423	150,489,935	133,805,841
Current YTD Income (Loss)	9,937,769	8,056,809	148,514	19,635,303
Total Net Assets / Reserves	187,953,632	186,072,672	178,164,377	178,015,863
Total Liabilities, Deferred Inflows, and Net Assets	**807,300,477**	**793,194,374**	**786,201,888**	**763,293,224**

Cash Flow – YTD

Cash Flows from Operating Activities	
Premiums Received	582,502,495
Medical Expenses Paid	(557,063,694)
Adminstrative Expenses Paid	(40,673,990)
Net Cash from Operating Activities	**($15,235,189)**
Cash Flows from Capital and Related Financing Activities	
Purchase of Capital Assets	(5,263,470)
Cash Flows from Investing Activities	
Interest Income and Other Income (Net)	2,376,444
Net Increase/(Decrease) in Cash & Cash Equivalents	**(18,122,216)**
Cash & Cash Equivalents (Jun 2018)	224,156,209
Cash & Cash Equivalents (Jan 19)	**$206,033,993**
Reconciliation of Operating Income to Net Cash from Operating Activities	
Operating Income/(Loss)	**$9,937,769**
Adjustments to Reconcile Operating Income to Net Cash from Operating Activities	
Depreciation	2,201,709
Changes in Operating Assets/Liabilities	
Premiums Receivable	(57,444,468)
Other Receivable	(2,376,444)
Due from Santa Clara Family Health Foundation	-
Prepaids & Other Assets	(1,623,239)
Deferred Outflow of Resources	-
Accounts Payable & Accrued Liabilities	(8,160,285)
State Payable	41,812,210
Santa Clara Valley Health Plan & Kaiser Payable	5,901,361
Net Pension Liability	525,000
Medical Cost Reserves & PDR	(8,551,778)
IHSS Payable	2,542,975
Deferred Inflow of Resources	-
Total Adjustments	**(27,374,667)**
Net Cash from Operating Activities	**($15,235,189)**

Statement of Operations - YTD

Santa Clara Family Health Plan

Santa Clara County Health Authority
Statement of Operations
By Line of Business (Including Allocated Expenses)
For Seven Months Ending January 31 2019

	Medi-Cal	CMC Medi-Cal	CMC Medicare	Total CMC	Healthy Kids	Grand Total
P&L (ALLOCATED BASIS)						
REVENUE	$ 510,034,471	$ 16,653,066	$ 68,997,526	$ 85,650,592	$ 2,449,690	**$ 598,134,753**
MEDICAL EXPENSE	$ 470,773,521	$ 17,650,417	$ 66,286,189	$ 83,936,605	$ 2,246,125	**$ 556,956,252**
(MLR)	92.3%	106.0%	96.1%	98.0%	91.7%	**93.1%**
GROSS MARGIN	$ 39,260,950	$ (997,351)	$ 2,711,337	$ 1,713,986	$ 203,565	**$ 41,178,501**
ADMINISTRATIVE EXPENSE	$ 27,861,150	$ 909,691	$ 3,769,060	$ 4,678,750	$ 133,817	**$ 32,673,718**
(% of Revenue Allocation)						
OPERATING INCOME/(LOSS)	$ 11,399,800	$ (1,907,041)	$ (1,057,723)	$ (2,964,764)	$ 69,748	**$ 8,504,784**
(% of Revenue Allocation)						
OTHER INCOME/(EXPENSE)	$ 1,221,919	$ 39,897	$ 165,301	$ 205,198	$ 5,869	**$ 1,432,986**
(% of Revenue Allocation)						
NET INCOME/(LOSS)	$ 12,621,719	$ (1,867,145)	$ (892,421)	$ (2,759,566)	$ 75,617	**$ 9,937,769**
PMPM (ALLOCATED BASIS)						
REVENUE	$ 298.23	$ 335.31	$ 1,293.69	$ 1,605.93	$ 106.96	**$ 334.82**
MEDICAL EXPENSES	$ 275.28	$ 355.39	$ 1,242.85	$ 1,573.79	$ 98.08	**$ 311.77**
GROSS MARGIN	$ 22.96	$ (20.08)	$ 50.84	$ 32.14	$ 8.89	**$ 23.05**
ADMINISTRATIVE EXPENSES	$ 16.29	$ 18.32	$ 70.67	$ 87.73	$ 5.84	**$ 18.29**
OPERATING INCOME/(LOSS)	$ 6.67	$ (38.40)	$ (19.83)	$ (55.59)	$ 3.05	**$ 4.76**
OTHER INCOME/(EXPENSE)	$ 0.71	$ 0.80	$ 3.10	$ 3.85	$ 0.26	**$ 0.80**
NET INCOME/(LOSS)	$ 7.38	$ (37.60)	$ (16.73)	$ (51.74)	$ 3.30	**$ 5.56**
ALLOCATION BASIS:						
MEMBER MONTHS - YTD	1,710,178	49,665	53,334	53,334	22,902	1,786,414
REVENUE BY LOB	85.3%	2.8%	11.5%	14.3%	0.4%	100.0%

HEALTHTrust

March 20, 2019

Ms. Christine Tomcala, CEO
Santa Clara Family Health Plan
6201 San Ignacio Ave
San Jose, CA 95119

Dear Ms. Tomcala,

On behalf of The Health Trust's Board of Trustees, staff, and community of clients and volunteers, thank you for your support of our Health Insurance Enrollment program. Directly targeting traditionally underserved communities in Santa Clara County, our walk-in informational clinic enrolls residents in Medi-Cal, CCHIP, and other insurance plans. Bilingual enrollment specialists work closely with clients to review what services are covered by insurance and to help them navigate their insurance plan and the network of services available within their coverage. The Health Trust does not steer or otherwise attempt to influence enrollment assistance recipients to enroll in insurance plans offered by Santa Clara Family Health Plan.

With your support, since May 2018, The Health Trust Health Insurance Enrollment program has processed over 400 insurance renewals and enrolled over 400 new families into medical coverage, representing nearly 1,300 children and 426 adults. **We hope to build on this success, with a request of $165,000 to continue the project from July 1, 2019-June 30, 2020.** In partnership with the Health Plan, The Health Trust will continue to strengthen access to health insurance and empower members of our community who are the most vulnerable to effectively navigate available health care services, in order to improve and maintain their health.

All Health Insurance Enrollment services take place at the Application Assistance Center at Western Dental Kids (formerly the Children's Dental Center) in East San Jose, and are available in English and Spanish. When a new client walks into the Health Insurance Enrollment office, staff review family eligibility and confirm they brought the necessary documents in order to apply. Staff and families complete the application forms together, and clients are referred to appropriate community-based programs to meet their immediate health needs, including food access, housing support, vision screenings, and dental programs. The Health Trust staff follow up with new clients after one month to confirm they received all confirmation paperwork from their insurance plans and know how to navigate their new coverage.

The majority of new enrollees are recruited by word-of-mouth from current clients, as well as exterior signage, and staff place a strong emphasis on friendly and high-quality customer service. Through a partnership with the Mexican Consulate in San Jose, The Health Trust operates the Ventanilla de Salud, which caters to Mexican nationals living in the Bay Area. One Health Insurance Enrollment staff spends part of her time at Ventanilla de Salud, and refers qualified families to the Application Assistance Center.

Renewed funding from Santa Clara Family Health Plan will support staffing, supervision, and direct program expenses of the Health Insurance Enrollment program for one year. Staffing needs consist of one full-time Enrollment Specialist, one part-time Program Associate, and a portion of the Program Manager's time to support monthly reporting and supervision. The Health Trust provides monthly quantitative and narrative reports to the Health Plan.

The Health Trust is uniquely situated to serve low-income residents in our community, many of whom are impacted by the social determinant stressors of poverty, housing instability, and uncertain immigration policy. As the founder of the Children's Dental Center in the Tropicana Shopping Center, home to the Health Insurance Enrollment program, The Health Trust is established as a trusted and reliable service provider ensuring access to high-quality care. Health Insurance Enrollment staff can refer new clients to other programs provided by The Health Trust, such as evidence-based health education workshops or food access, and services offered by other community organizations. Once a month, in partnership with Second Harvest Food Bank, The Health Trust distributes free fresh and healthy food, right outside the office. The shared office space is also available to host health seminars and workshops targeting residents of East San Jose.

The Health Trust believes the overall well-being of every person is affected by the social determinants of health: their access to affordable health care, adequate income, food, social engagement, and safe housing. This belief underlies our services to address the health of people who are underserved - and is in direct alignment with the Health Plan's mission to provide high quality, comprehensive health care coverage for those who do not have access to, or are not able to purchase, good health care at an affordable price.

Thank you for your support, and we look forward to continuing our partnership to reach more residents of Santa Clara County. If you have any questions, please do not hesitate to contact Maia Bookoff, Development Manager - Grants (maiab@healthtrust.org or 408-513-8709).

Yours in Health,

Michele Lew
Chief Executive Officer